Foreword

Universal Health Coverage: A Return to Alma-Ata and Ottawa

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In 1978, the Alma-Ata Declaration established a bold plan for global health action and social justice, identifying primary health care as the lynchpin for achieving health for all.[1] Several years later, the Ottawa Charter for Health Promotion, responding to growing health challenges within industrialized societies, formally recognized underlying determinants as an integrated and vital part of health for all.[2] United Nations agencies, national governments, and a range of civil society organizations endorsed these declarations, recognizing access to health care and underlying determinants as a human right. Implicit in this recognition was the emerging obligation of nations to establish health policies responsive to underlying determinants and to ensure universally accessible primary health care. This early consensus for universal health care was soon challenged by political and economic developments of the 1980s, when neoliberalism and structural adjustment programs delivered a devastating blow to the health sector and the objectives of Alma-Ata.[3] World Bank economists and other development actors successfully exported the case for user fees and private sector financing, which subsequently shaped the trajectory for health systems in many low- and middle-income countries for more than three decades.[4] These user fees have left a devastating legacy, deepening inequality, and poverty, and are referred to by the current World Bank president as "unjust and unnecessary."[5] For those countries isolated from neoliberalism during the Cold War, specifically in Soviet bloc countries, state-run, centralized health bureaucracies flourished, where excessive biomedical treatments and specialization were privileged at the cost of evidence-based prevention, health promotion, and respect for the human rights of all users of health services—particularly undermining the values expressed in Ottawa. These publicly financed health systems, while claiming universalism, left an equally devastating legacy of inequality, corruption, and systematic human rights abuse within health care systems.

How we overcome these inherited legacies of health financing, how we define health, and how we achieve equitable access is at the heart of the current struggle for universal health coverage (UHC), one of the most ambitious global health developments of our time. Calls from the World Health Assembly urging states to strive for "affordable universal coverage and access for all citizens on the basis of equity and solidarity" signal a welcome return to the principles of Alma-Ata and Ottawa.[6] The World Bank's current president, Jim Yong Kim, has promisingly affirmed that the values of Alma-Ata must be harnessed in the movement toward UHC.[7] UHC is now part of the Sustainable Development Goals, a global political com-

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mitment adopted by the United Nations General Assembly in 2015. In November of this year, national governments and international organizations will renew the spirit of Ottawa in light of the 2030 agenda with the Shanghai Declaration and Plan of Action on Health Promotion.[8] Today, achieving UHC is not merely an aspirational call for action—it is an attainable global health imperative within our reach. However, in this global transition toward UHC, the world's poorest and most marginalized remain at risk of being left behind. The effective integration of human rights standards and principles within national, regional, and international UHC implementation strategies and programs can mitigate these risks, fortify health and well-being, and further the promotion and protection of human rights for all.

In the decades since Alma-Ata and Ottawa, human rights, particularly the right to the highest standard of physical and mental health, have evolved in both substance and content. This rich understanding of the right to health can now be applied to health policy in an operational, practical, and systematic way and is of particular relevance as states advance in their SDG commitments to achieve UHC by 2030.

It is this convergence of global processes and commitments, the renewed spirit of Alma-Ata and Ottawa, and the practical and legally binding nature of the right to the highest attainable standard of health that led me to address (albeit not in depth) UHC, the right to health, and the Sustainable Development Goals in my latest report to the United Nations General Assembly.[9]

Moving toward rights-based UHC

While UHC has been called "a practical expression" of the right to health, not all paths to UHC are consistent with human rights requirements.[10] In my report to the General Assembly, I emphasized that UHC *must* be understood to be consistent with the right to health. Therefore, UHC cannot be narrowly defined as economic access but must integrate a right to health framework that secures promotive, preventive, curative, and palliative care services for all without discrimination.[11] The intersection of UHC and human rights is a large, complex topic that, from the perspective of the right to health, must include a number of elements. To explore these in depth within the scope of my report to the General Assembly would have been impossible. While I plan to devote space to UHC in my future work, I chose to focus this report on but a few features required to establish rights-based UHC, some of which I highlight for readers below.

Ensuring the prioritization and participation of the world's most vulnerable

The 17 Sustainable Development Goals of the 2030 agenda reflect a holistic approach to transforming the world into a more peaceful, just, and inclusive global community. Health is central to the SDGs as both a path and an outcome to ending poverty and achieving sustainable human development. There is an overarching commitment to implement the SDGs in a manner that is consistent with international human rights law. However, as we move from the 17 goals to their associated targets and indicators to measure progress and set priorities for action, critical rights elements, particularly the right to health, are absent. Goal 3, particularly Goal 3.8 on UHC, and its indicators are entirely reductive in content. There is no explicit commitment to confer priority to the poor and marginalized, either in the process of expanding coverage or in developing priorities as to which services to provide. This is despite core obligations under the right to health to guarantee access to health services without discrimination and to take deliberate, targeted, and concrete steps to ensure the effective realization of that guarantee, especially for the most marginalized.

Ensuring the participation of the world's most vulnerable is vital to defining and achieving equitable UHC. States have a core obligation to guarantee effective and meaningful participation in the development of national health plans, including strategies for UHC that, at a minimum, ensure the incorporation of the views of the poor and most marginalized. If the furthest behind are not prioritized, and if progressive strategies for expanding coverage for the most marginalized are

not immediately established with their active participation, there is little hope this target will be met by 2030. Equally, some have argued that this risks a situation where the easiest way to report progress on UHC is to focus provision on those portions of the population who are already closest to the target, deepening inequality and poverty.[12]

Strategies to define health packages

I also emphasize in my report that UHC cannot be achieved without health care services meeting the core requirements of availability, accessibility, acceptability, and quality under the right to health. Among other things, services must be safely and geographically accessible without discrimination. The right to health requires that essential services include those for populations with specialized needs, such as sexual and reproductive health services adapted to the needs of women, girls, persons with disabilities, and transgender persons. Health services and access to underlying determinants must also be economically accessible. Even where there is widespread access to health services, the right to health demands that they be of sufficient quality, including in good working condition and medically and scientifically appropriate. The right to health recognizes the importance of prioritizing investments in primary and preventive care, which benefits a larger population than expensive specialized health services, often only accessible to a small, privileged fraction of the population. Investing in primary health services prevents illness, promotes mental and physical health, and in turn reduces the need for specialized care. This core framework is entirely absent from the SDG indicators for UHC.

States will not achieve Goal 3 without a robust commitment to addressing social and psychosocial determinants of health, as well as inequalities in income, education, living and working conditions, and distribution of resources. As UHC is a key determinant of success toward achieving Goal 3, how services are defined must not be limited to biomedical interventions such as medicines and vaccines, though the indicators to measure UHC appear to focus on this reductive conceptualization. As I have emphasized in past reports, the achievement of the highest attainable standard of health requires scaled up investment in modern interventions that go beyond the biomedical model, including psychosocial and other interventions that address structural and environmental barriers to health. This vital component to achieving equitable expansion and access to UHC and securing the right to health remains absent from the targets and indicators for health.

As a mental health professional and as Special Rapporteur on the right to the highest attainable standard of *mental* and physical health, I have consistently raised concerns regarding the grossly unmet global need for rights-based mental health services. While the 2030 agenda affirms that UHC and access to quality health care are necessary to promote mental health and well-being, this falls short of the World Health Organization's Comprehensive Mental Health Action Plan, which requires comprehensive strategies for promotion, prevention, treatment, *and* recovery.[13] UHC is a crosscutting principle to ensure equity for those in need of mental health services and to promote societal well-being. Lack of political will to address mental health as an emerging priority has given rise to two scenarios that are equally problematic from a right to health perspective: either mental health services are not available for those who need them (particularly in low- and middle-income countries), or, where services do exist, they often violate the rights of people receiving care. The progressive move toward UHC is a window of opportunity to reform and scale up mental health services that respect, protect, and fulfil the right to health. Psychosocial and public health interventions that empower people, increase their resilience, and address structural factors that contribute to mental ill health must be the touchstone by which to define services, on par with the provision of appropriate and high-quality medications. These interventions must be viewed as part of primary, community-based health care and as an integral part of UHC.[14]

Financial risk protection

As already referred to, the legacy of user fees and catastrophic out-of-pocket health expenditures is why many countries find themselves still strug-

gling to achieve UHC 30 years after Alma-Ata. Still today, in many countries, out-of-pocket payments—such as user fees and co-payments, fees for treatment, and indirect fees related to the costs of seeking health care (transportation costs, informal charges, opportunity costs/loss of work, discrimination)—create major barriers to health care.

These costs are often significant and disproportionately affect the poor, who spend a considerably larger portion of their total income on health. In turn, they drive many households into poverty or deepen the poverty of those who are already poor. These fees may bar those without the means to pay from receiving needed care, as well as discourage people from seeking care in the first place.

Despite this, private, out-of-pocket payments account for around 50% of total health expenditures in countries where more than 50% of the population is living on less than US$2 a day. This means that it is the poorest and most in need who suffer from these payments.[15] UHC consistent with the right to health requires establishing a financing system that is equitable and that pays special attention to the poor and others unable to pay for health care services, such as children and adolescents.

Conclusion

While the momentum to progressively achieve UHC presents a host of complex human rights and political challenges in both defining and financing health care packages, the momentum toward achieving equitable expansion is stronger today than ever before. In health-related policies, the implementation of good ideas has always been complicated. Although UHC is a simple and noble proposal, based on common sense and the need for basic health care to reach everybody, I wish to warn against the perils of the low-hanging fruit and of simplifying approaches to UHC and the process toward reaching it. How we understand UHC in relation to human rights is critical to achieving health equity and well-being for our global community. It is precisely these challenges that this special section on UHC seeks to begin to address, making this publication an important and timely contribution to this next transition in global health.

References

1. International Conference on Primary Health Care: Declaration of Alma-Ata, Alma-Ata, September 6–12, 1998.

2. First International Conference on Health Promotion: Ottawa Charter for Health Promotion, Ottawa, November 21, 1986.

3. A. Chapman, *Global health, human rights and the challenge of neoliberal policies* (New York: Cambridge University Press, 2016), ch. 8.

4. M. Thobani, *Charging user fees for social services: The case for education in Malawi*, World Bank Staff Working Papers, No. 572 (1984); R. Rowden, "The ghosts of user fees past: Exploring accountability for victims of a 30-year economic policy mistake," *Health and Human Rights* 15/1 (2013); Chapman (see note 3).

5. See World Bank, *World Bank Group president Jim Yong Kim's speech at World Health Assembly: Poverty, health and the human future* (May 21, 2013). Available at http://www.worldbank.org/en/news/speech/2013/05/21/world-bank-group-president-jim-yong-kim-speech-at-world-health-assembly.

6. World Health Assembly, *Sustainable health financing structures and universal coverage* (2011), p. 2. Available at http://apps.who.int/gb/ebwha/pdf_files/EB128/B128_R8-en.pdf.

7. World Bank (see note 5).

8. See http://www.who.int/healthpromotion/conferences/9gchp/shanghai-declaration/en.

9. Report of the Special Rapporteur on the right to the highest attainable standard of mental and physical health, UN Doc. A/71/304 (2016), paras. 74–90.

10. World Health Organization, *Positioning health in the post-2015 development agenda*, WHO Discussion Paper (Geneva: United Nations, 2012).

11. International Covenant on Economic, Social, and Cultural Rights, G.A. Res. 2200A (XXI) (1966), art. 12.2; Committee on Economic, Social, and Cultural Rights, General Comment 14, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4 (2000), para. 17.

12. Chapman (see note 3), p. 319.

13. World Health Organization, *Comprehensive mental health action plan (2013–2020)* (Geneva: World Health Organization, 2013).

14. Ibid.

15. International Labour Office, Social Protection Department, *Addressing the global health crisis: Universal health protection policies*, Social protection policy papers, No. 13 (Geneva: International Labour Organization, 2014).