

March 27, 2024

Right to Healthcare in Times of Universal Health Coverage

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Healthcare for all needs three things working together—a law guaranteeing the right to healthcare; universal health coverage to pay for it; and a focus on primary care to deliver it effectively. Each part should strengthen the others, creating a system that prioritises people’s health, not profits.

At a time when cash transfers seem to have become the preferred solution to the state providing citizens with assured access to basic entitlements, the right to health is proving to be something of an exception. A pandemic that exposed the capacities and inequities of health systems the world over might be an important part of the reason. But the space for engagement has also been activated in some Indian states. Assam and Rajasthan have moved legislation on the subject, while others such as Tamil Nadu are debating the need for an act.

Most policy conversations around the right to health, however, are plagued by grave doubts. Often, the scepticism is expressed in somewhat vague terms. A common refrain is that a rights-based approach has inherent limitations. However, one encounters three serious concerns.

First, based on a growing list of countries and states that have legislated the right to health, there is a fairly strong consensus that legislation alone does little to translate into sustained political commitment and institutional capacity. This leads one to ask whether having an unrealised and weakly justiciable right is even worse than waging a campaign for an unlegislated demand.

There is also evidence of impressive performance in the absence of legal entitlement. Countries such as Sri Lanka were already doing a competent job of providing universal health coverage without a right to health law. That they are now in danger of losing these gains due to financial and other crises is another matter and it remains unclear whether a legislation would have been able to prevent this. In India, states such as Tamil Nadu and Kerala have been able to deliver better on healthcare coverage than most other states without enacting legislation.

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Second, there is a real fear, often articulated by committed administrators, that while the gains from legislation are uncertain at best, the bureaucratic and fiscal costs are liable to be explosive. As one leading health administrator put it to us, “What additional advantage will a legal right provide? It would only tie us down in litigations and contestations. Given both our constraints in human resource management and finances, we will hardly be able to close all the gaps. Instead, this kind of legislation would then force us to change our priorities on the basis of legal rulings.”

This last statement leads to a third major concern, that under the right to health, court rulings will bear down on the state to include costly treatments for rare diseases, re-prioritising public finance towards a select few who can afford to fight cases and benefiting the pharmaceutical companies that provide the treatments.

Here, the Latin American experience seems to sound an alarm. A [recent commentary](#) in *The Lancet* not only describes a “spectacular growth of litigation by citizens against governments where this right is enforceable in courts” but also points out how, “in some instances, these cases have been brought forward by the rich, seeking high-priced medications and experimental treatments. In others, pharmaceutical companies have been found to have had an active role in bringing right to health cases to court.”

Each of these dangers is real. But they are not inevitable. A great deal depends on first getting the definitions right and then in how they are translated in law, health systems organisation, and in accountable financial arrangements.

Three concepts are globally accepted as key strategies in the construction of health systems: the right to healthcare, universal health coverage, and primary health care. The three are often either taken up as independent strategies or placed in subordinate and linear, or even conflicting and contradictory, relationships. Instead, it would be better to first understand each one clearly and then build up a

relational perspective.

There is a necessary and essential relationship between all three concepts. Together, they provide a framework for shaping and supporting health systems to achieve significant, sustainable, and equitable improvements in health outcomes at varied levels of development. We illustrate the case by drawing on examples from diverse contexts and attempt to clarify some critical pre-conditions and key design features to address the tangible concerns raised above.

The right to health encompasses the critical and wider domain of public health and must include a commitment to address the multiple social and commercial determinants of health across the population.

But we must understand how the right to health and universal health coverage have become regressively entangled in discourse and practice. How is it that we have reached a point where we must worry that health rights are liable to be used to expand the entitlements of the rich? Why has universal coverage come to be predominantly associated with the public financing of private provision and big pharma rather than with the strengthening of public health systems to ensure access for all?

Twists and turns

By definition, the right to healthcare and universal health coverage (UHC) should go together. The right to healthcare is a subset of the larger right to health. The latter also encompasses the critical and wider domain of public health and must include a commitment to address the multiple social and commercial determinants of health across the population.

The right to healthcare is legislation that assures all people will have access to a set of healthcare services that are timely, of good quality, and can be accessed without financial hardship. They will be provided with dignity and in a manner respectful of the rights of the users, and without discrimination. This implies that there are health systems in place that can deliver these services and that the government holds itself accountable for providing healthcare.



A health system capable of delivering all healthcare services as needed would also be consistent with the official definition of universal health coverage, which runs as follows: “Universal health coverage means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course.”

In formal policy statements, both the WHO and the World Bank take pains to emphasise that countries should be free to choose their own roadmaps to universal health coverage. In practice, universal health coverage has become associated with a specific form of publicly-funded health insurance scheme that provides coverage for a limited set of services. Financial protection, although formally assured, is seldom enforceable. This is why sections of civil society and others prefer UHC to stand for 'universal health *care*' instead of 'universal health coverage', to ensure that the term denotes universal access and is not trivialised to enrolment in an insurance scheme.

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Since insurance is only a means of financing in contexts where physical access to good quality health services is itself a problem, insurance has little to offer in terms of additional coverage. One might therefore assume that universal health coverage would prioritise the task of strengthening public health services, which remain the most important source of healthcare with financial protection, especially for the poor.

Instead, the predominant model that has come to be associated with universal health coverage is one that favours publicly financed private provision by a network of empanelled healthcare providers. When this mode of universal health coverage is brought under a right to health law, three major problems tend to arise.

The first limitation is the difficulty of enforcing a right of access by an empanelled private provider. While a state could certainly make it a contractual obligation of the private provider to provide access as a right, in practice, this is never fully enforced. The threat of enforcement tends to lead to the exit of the private provider. As a result, there is little effective recourse to prevent denials of benefits to eligible insured persons.

There is an even bigger danger involved in the predominant model of publicly financed private empanelled health providers. Most publicly funded insurance schemes work with a well-defined budget. The size of the budget is defined by the premium per family multiplied by the number of families covered. This pays for a limited number of in-patient secondary or tertiary care episodes. If costly packages are introduced to the scheme because it is more profitable for the private sector to provide certain services or medicines, the utilisation of these packages will be higher, displacing a large number of necessary and less costly services.

This displacement is not obvious. It often takes the form of denial of insurance by third party administrators on procedural grounds. Third party administrators are tasked with keeping the total approved claims within budget limits. On the other hand, if under pressure from courts to enforce the right to health, budgets are allowed to expand, there will be a shift of utilisation of the costlier packages, which the more privileged are usually better able to secure.

This is why a right to healthcare that is linked to insurance schemes, where reimbursement is on a fee-per-service package basis, and where the majority of providers are private providers, is a likely prescription for fiscal profligacy (also called fiscal incontinence) and health inequity.

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Countries such as Japan, Germany, Canada, and Australia have insurance schemes where the majority of healthcare providers are private providers. But these are all health systems where all (or almost all) providers must be empanelled, all residents must be enrolled, rates are fixed and applicable to all, and all working staff payments are negotiated and fixed.

Further, in countries such as Japan, private profit from healthcare is specifically disallowed by law. To get to such a situation, a country must not only be able to enforce such strict regulations, but also be able to pay a much higher fee to providers. Each of these countries have public health expenditures of at least 10% of their gross domestic product (GDP) or more, and they are all high-income nations with very sizeable GDPs per capita.

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Key design features

From this, one might draw the conclusion that states should only legislate on the right to health after crossing a certain threshold of public health expenditure. But, by accepting this as a binding constraint, one gives up on an opportunity for a framework that uses the healthy tension and essential complementarity between the legal right to health and universal health coverage to effectively organise, prioritise, and build better health systems and capacities at all levels of development.

In the context of Indian states, it makes sense to focus on a set of key conditions and design features. Amongst these, it is most important is to recognise the organisational centrality of primary healthcare, which is at the heart of these relationships.

Public provision: First, a meaningful right to healthcare law in the context of Indian states is possible only if we have a system of universal health coverage in place where the public health services and publicly administered services can cater to all those who need them. The term 'publicly administered services' is important and refers to service providers who are privately owned but who choose to come under the ambit of essential health services as defined and assured by the law through suitable contracts. The key design features of the health system through which such health services can be accessed as an entitlement must be indicated in the legal text.

The Thai case is important here. Thailand's [National Health Security Act, 2002](#) makes it mandatory for registration with a primary care network and this act of registration gives citizens a legal entitlement to access all the healthcare services they require (sections 5-7). There is also a legal guarantee to reimburse all service providers the cost of services provided under the act (section 46). And all providers have to adhere to the service package and costs decided upon objectively by a duly constituted board (section 10, 46 of the act).

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Crucially, while the law is not restricted to public providers, in practice, due to enforcement of transparent contractual arrangements and costing, more than 95% of the empanelled providers are public, except in Bangkok city where the mix is approximately 50-50. The dominance of public provisioning has ensured that universal health coverage is both affordable and of good quality.

Priority setting: Given that resources are finite, who is to decide (and how) what makes it in and out of the health services package? Will such decisions stand in a court of law? The tried and tested solution is for the law to make it clear that the choices regarding the health services to be included as well as the costs of care that must be reimbursed to providers will be defined by a duly constituted committee using a well-defined process. Such committees need to be guided by health technology assessment techniques centred around cost effectiveness studies and a deliberative process that considers concerns related to equity and ethics.

New procedures will have to demonstrate that they fall within an agreed cost-effectiveness threshold value. They must also prove that the new services will not displace other essential care for the many within the available budget.

Well-known examples include the UK's National Institute for Health and Care Excellence ([NICE](#)), established in 1999, which provides the scientific evidence of comparative clinical and cost effectiveness to arrive at the best value for money in terms of quality, equity and efficiency of the National Health Service (NHS). Thailand's National Health Security Act provides for a quality and standards control board with a mandate to finalise the package of services and the cost estimates for reimbursement. They have also created a health intervention and technology assessment programme to undertake the required studies to inform these decisions.

Non-confrontational forms of accountability: Putting a robust and fair grievance redressal strategy in place can go a long way towards avoiding significant increases in legal contestation. Thailand has what is called a no-fault liability clause in its act (section 41), which ensures that errors and denials or illegal charges are compensated if found to be true, without necessarily having to fix which individual provider is to be held accountable for it. This helps because the gaps are often systemic and medical errors do occur. Of the budget, 1% is earmarked for compensation and currently about 0.3% is spent. There is also a supportive local civil society arrangement that helps the complainant and ensures that there is a greater understanding of the constraints amongst both providers and service users, which builds solidarity instead of a confrontational form of accountability.

Primary health care as an approach: The single most important need is for states to reorient and reorganise their health systems, consciously and foundationally based on a comprehensive primary healthcare approach. The characterisation of comprehensive care must be contrasted with the earlier policy that adopted selective packages, which included only some aspects of reproductive health services

and a few disease control programmes while the rest were left to private markets. This meant that more than 85% of healthcare needs were not effectively covered. In the current understanding, most diseases have some aspects of care that are best delivered at the primary level.

Comprehensive care must be contrasted with the earlier policy that adopted selective packages, which included only some aspects of reproductive health services and a few disease control programmes, while the rest were left to private markets.

Here, the primary health centre provides services related to prevention and early detection of a large number of communicable and non-communicable diseases. It also ensures that there is medication compliance, follow up, and prevention of complications at the primary care level even for chronic illnesses diagnosed at higher levels of care. Most importantly, when consultation at a higher level is required, it is the primary care provider who acts as a guide and facilitator to access such care.

A network of primary health care providers must be community-based in the sense that services are organised as close to communities as is convenient. And this is population-based healthcare, where the primary healthcare provider is responsible for the highest attainable health outcomes in the entire population and not only for those who seek care.

Internalising this understanding is the key to both delivering cost-effective and accessible universal coverage. It is also the key to making access to healthcare a right and a legal entitlement that is enforceable.

Registration and entitlements: In such a health system, every family and individual is registered with a primary healthcare provider. This registration is the means through which they access all preventive, promotive, and curative services as required, and feasible, at that level. It is also the portal through which they have assured timely and free access to all the secondary and tertiary care that is available under the health service. In effect, the act of registration is the act of securing delivery of the entitlement.

Patients who walk in directly to a higher centre cannot be denied care, but they are not assured of the continuity of care across levels that they would get if they had come in as referrals from their primary facility of registration.

Value addition and resource use: By clarifying where the entitlements lie, such legislation enables citizens to claim their entitlements when necessary and to call out denials to accountable authority structures. Equally important, clarity in entitlements and delivery provides more value for money. By guiding appropriate health-seeking behaviour through legally assured primary care providers, referral links, and continuity of care, we could get much better health outcomes in relation to the societal health expenditure incurred.

To succeed, a primary healthcare approach needs a commitment to universal health coverage, which needs to be protected by a law that ensures the nature of the service as a public good rather than as a market commodity.

This, then, is the necessary relationship between legal entitlement, accountable financial coverage, and accessible, quality care. The right to healthcare requires universal health coverage, which in turn needs a primary healthcare approach.

But the reverse logic is also true. To succeed, a primary healthcare approach needs a commitment to universal health coverage, which needs to be protected by a law that ensures the nature of the service as a public good rather than as a market commodity.

In a period where welfare schemes providing actual access to necessary entitlements are systematically being replaced by conditional cash transfers, which provide only notional access while legitimising a public policy discourse in favour of dismantling public services, a right to healthcare law would help state governments protect their investments in the development of public health services. It would also help build the public imagination of what can be.