PART 1
ADVANCING THE RIGHT TO HEALTH THROUGH LAW REFORM
Chapter 1: Public health regulation and the right to health

SUMMARY POINTS

- The human right to health, understood as the right to the highest attainable standard of health, provides an overarching and exacting standard to guide the actions of governments as they strengthen their health systems by reforming their public health laws.

- The principles of availability, accessibility, acceptability and quality are essential elements of the right to health. They serve a diagnostic function, drawing attention to what remains to be done as governments move towards universal health coverage. By increasing the capacity and quality of health care and public health services, by ensuring that the entire population is covered by these services, and by ensuring that these services remain affordable to everyone, governments can help to respect, protect and fulfil the right to health.

- The principles set out above provide guidance to governments as they make decisions about the goals, resources, focus and scale of public health law reform activities. Although the precise form that the law takes will vary significantly between countries, law has a flexible and enabling role in helping to realize the right to health. For example, the law has a role in: eliminating discriminatory barriers to the accessibility of health services, ensuring the accountability of health service providers, strengthening the components of an effective health system, creating a framework for the discharge of core public health functions, and reducing health inequalities.

1.1 Justifications for public health regulation

A variety of theoretical justifications have been put forward to justify public health regulation. These include reducing externalities (such as protecting non-smokers from second-hand smoke or improving suboptimal vaccination rates), or increasing the production of public goods (by improving air quality, or vector control). Regulation may also aim to provide consumers with better information about harmful goods (such as health warnings on tobacco and alcohol products), or seek to improve their capacity to make healthier choices, for example through front-of-pack food labelling that interprets the nutritional content of food.

Other theoretical justifications for regulation pay greater attention to the persistence of health inequalities, to the role that a healthy population plays in economic and social development, and to shared agreement around the goal of “health for all”. These ideas, which were powerfully expressed in the Alma Ata Declaration (1978) and in the Rio Declaration on Social Determinants of Health (2011) continue to inspire health sector reform efforts, and provide a justification for the role that public health law reform plays in health development generally.
The approach to public health law reform taken in this report rests on two fundamental human rights concepts: the rule of law, and the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (hereafter the right to health). The rule of law refers to the principle that law-making processes should be transparent, laws should be enforced fairly, courts and tribunals should be independent, and the administration of law and its substantive content should be consistent with international human rights standards (Box 1.1).

**Box 1.1: Public health and the “rule of law”**

The rule of law is a fundamental concept within the United Nations system. It requires that “laws must be publicly promulgated, equally enforced and independently adjudicated and [must be] consistent with international human rights norms and standards”. Under the rule of law, “all persons, institutions and entities, public and private, including the State itself, are accountable to just, fair and equitable laws and are entitled without any discrimination to equal protection of the law”. The United Nations General Assembly has acknowledged that advancing the rule of law at national and international levels is “essential for sustained and inclusive economic growth, sustainable development, the eradication of poverty and hunger and the full realization of all human rights and freedoms, including the right to development”.

The right to health is a human right that is well-established in international law (Box 1.2). Most countries in the world have ratified at least one international agreement that imposes specific obligations on governments regarding the right to health. The right to health is recognized in the Universal Declaration of Human Rights, in the International Covenant on Economic, Social and Cultural Rights (ICESCR), and in a number of other international human rights treaties including the Convention on the Rights of the Child.

**Box 1.2: What are human rights?**

Human rights are legal guarantees protecting universal values of human dignity and freedom. Human rights define the entitlements of all human beings and the corresponding obligations of the State as the primary duty-bearer. Human rights have been negotiated by States and agreed upon in human rights treaties, such as conventions and covenants, which are legally binding on States that are parties to them.

Although this report focuses mainly on the right to health, as recognized in the ICESCR and a number of regional human rights treaties, there are a variety of other health-related rights in international law that support actions by government to improve the health of their populations. These include the right to adequate food, clothing and housing, the right to freedom from hunger, and the right to environmental and industrial hygiene in the ICESCR (Articles 11 and 12). Other rights include the right to liberty and security of the person, freedom from coerced labour, liberty of movement, freedom of thought, conscience and religion and freedom from discrimination on grounds including race, colour, sex, language, religion and political opinion, as recognized in the International Covenant on Civil and Political Rights (Articles 4, 8, 9, 12, 18 and 26).
The right to health has also been included in three major regional human rights agreements, in Africa,13 Europe14 and the Americas.15 For example, Article 16 of the African Charter on Human and Peoples’ Rights states:

1. Every individual shall have the right to enjoy the best attainable state of physical and mental health.

2. States Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

In some countries, the right to health has been recognized in the national constitution. For example, in Article 6 of the Constitution of the Federal Republic of Brazil, health is designated as a social right. The right to health is further reinforced by Article 196, which states:

Health is the right of all persons and the duty of the State and is guaranteed by means of social and economic policies aimed at reducing the risk of illness and other hazards and at universal and equal access to all actions and services for the promotion, protection and recovery of health.16

The Constitution of South Africa guarantees access to health services, including reproductive health and emergency services, basic health care for children, and medical services for detained persons and prisoners.17

Similarly, the Constitution of Mongolia declares that citizens shall enjoy the right to a healthy and safe environment, and the right to the protection of health and medical care.18 In turn, citizens owe a duty to protect their own health.19

The substantive obligations embodied within the right to health were clarified by the United Nations Committee on Economic, Social and Cultural Rights (CESCR) in General Comment 14.20 General Comment 14 explains that the right to health is an inclusive right that extends beyond health care to the underlying determinants of health, including access to safe and potable water, adequate sanitation, an adequate supply of safe food and nutrition, housing, healthy occupational and environmental conditions, access to health-related education and information, including on sexual and reproductive health, and freedom from discrimination.21 States have an obligation to take immediate steps to progressively ensure that services, goods and facilities are available, accessible, acceptable and of good quality. These obligations are discussed further in Section 1.1.

The right to health imposes three distinct obligations on States that are parties to the ICESCR. States have an obligation to respect, to protect, and to fulfil the right to health:22

- **Respecting** the right to health means not interfering directly or indirectly with the enjoyment of the right. For example, States may breach this obligation by unlawfully polluting the air, water and soil, by unjustifiably denying or limiting access to health care services, by limiting access to contraceptives and by withholding or misrepresenting health information, including sexual health information.

- **Protecting** the right to health means taking the actions that are necessary to prevent third parties from interfering with the right. For example, this requires States to adopt legislative
or other measures to ensure that registered medical practitioners and other health professionals have achieved appropriate standards of education, professional skill and ethics. Protecting the right to health also requires States to take measures to protect marginalized and vulnerable groups in society from violence: this includes protecting women and children from being coerced into undergoing female genital mutilation and other harmful procedures.

- **Fulfilling** the right to health means taking actions to facilitate, provide and promote the conditions in which the right can be fully realized. This requires States to adopt a national health policy and to implement legislative measures that seek to realize the right. The obligation to fulfil the right to health requires States to ensure the provision of adequate health services, including immunization programmes, equal access to basic sanitation services, nutritious and safe food, and safe drinking water. It requires States to consider the infrastructure requirements for the provision of health services, including the provision of an adequately trained workforce, as well as hospitals and other health-related facilities that are culturally appropriate and respond to the needs of vulnerable and marginalized groups. It requires States to ensure the availability of a health insurance system (whether public, private, or mixed) that is affordable for all. States must promote medical research and health education, and disseminate information to meet the health needs of the population. Information campaigns should include information relating to healthy lifestyles and nutrition, the availability of health services, harmful traditional practices, HIV/AIDS, sexual and reproductive health, domestic violence, the harmful use of alcohol, and the use of tobacco and other drugs. States are required to take appropriate actions to respond to environmental and occupational health hazards, and other threats that have been demonstrated by epidemiological evidence, and to provide a coherent national policy on occupational accidents.

(a) **Obligations of immediate effect under the right to health**

As explained in General Comment 14, the right to health requires States to take concrete steps towards ensuring the availability and accessibility of quality public health and health care services, especially for socially disadvantaged and marginalized groups. Although the right to health acknowledges resource constraints and is subject to progressive realization, certain obligations are of immediate effect.

For example, countries owe an immediate obligation to ensure that the right to access health services and other underlying determinants of health (e.g. sanitation and potable water) is not undermined by discrimination on grounds recognized in the Covenant. These grounds include discrimination on the basis of “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 and civil, political, social or other status”. For example, in the case of children and adolescents, the principle of non-discrimination precludes preferential feeding or medical treatment for boys at the expense of girls. In societies that are sharply divided between different ethnic groups, it requires health service providers to be blind to these differences and to treat everyone with dignity and respect. In some countries, HIV-related stigma and discrimination
are widespread: governments may need to take bold measures to confront and reduce this in order to overcome the disincentives that prevent people, including mothers and children, from being tested and accessing the treatments they need.30

Another important obligation of immediate effect is the obligation to take “deliberate, concrete and targeted” steps towards the full realization of the right to health. A useful starting-point is to adopt and implement a national public health strategy and plan of action, based on the specific health needs of the population. A national strategy and plan of action are identified elsewhere in General Comment 14 as one of a number of “core obligations” that arise from the right to health.31 National public health strategies and plans of action should be developed through processes that facilitate community participation, with clear goals, targets, health indicators and time frames to enable monitoring of progress and evaluation.32

(b) Core obligations arising under the right to health

Separate from the obligations of immediate effect discussed above, General Comment 14 identifies a number of core obligations that arise under the right to health. These core obligations may be seen as priorities for action as States move as quickly as possible towards the full realization of the right to health. These core obligations are summarized in Box 1.3.

Box 1.3: Core obligations arising under the right to health33

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<tr>
<th>The right to health in Article 12 of the ICESCR, as interpreted by the CESCR in its General Comment 14, imposes a number of core obligations. These include the obligations to:</th>
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<td>• ensure the right of access to health services without discrimination;</td>
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<td>• ensure access to food that is safe and nutritionally adequate and to ensure freedom from hunger;</td>
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<td>• ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;</td>
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<td>• provide essential medicines, as defined by WHO from time to time;</td>
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<td>• ensure equitable distribution of health facilities, goods and services;</td>
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<td>• adopt and implement a national plan of action addressing the health concerns of the population.</td>
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In addition to the core obligations above, there are a number of obligations of “comparable priority”. These include the obligations to:

| • ensure reproductive, prenatal and postnatal maternal and child health care; |
| • provide immunization for priority diseases; |
| • prevent, treat and control epidemic and endemic diseases; |
| • provide education about the major health challenges facing the community; |
| • provide appropriate training for health personnel, including education on health and human rights. |
The right to health and health systems

In order to respect, protect and fulfill the right to health, States must invest in the components or building blocks of an effective health system. WHO’s definition of a health system encompasses all the “organizations, people and actions whose primary intent is to promote, restore or maintain health”. This includes not only the provision of health services by government and the private sector, but public policies directed at the determinants of health, regulatory frameworks, health legislation and intersectoral efforts by government ministries to support the determinants of better health. Table 1.1 summarizes the building blocks of WHO’s health system framework. Laws, fiscal strategies and governance frameworks support each of the components of an effective health system, and are tools for further strengthening it.

Table 1.1: Building blocks of a well-functioning health system

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<tr>
<th>Leadership and governance: includes policies, strategies, laws, incentives, enforcement and accountability mechanisms. Includes governance structures to improve leadership and to facilitate intersectoral action to improve health.</th>
<th>Health information systems: includes the collection, production, management, analysis and sharing of information on health status, health determinants, and all aspects of health system performance (including progress in meeting health goals and targets, improving equity, and efficient use of resources).</th>
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<td>Health financing: financing structures to raise sufficient funds and to share financial risks across the population. By removing financial barriers and by preventing catastrophic expenditure, an effective health financing system ensures that the full range of quality health services are available to the entire population, according to need.</td>
<td>Human resources for health: includes a competent health workforce that is available in sufficient numbers, comprises an appropriate mix of functions, is fairly distributed, competent, responsive and productive. Includes payment systems, incentives and regulatory mechanisms to ensure the effective and sustainable delivery of high-quality services.</td>
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<tr>
<td>Delivery of health services: both personal and population-level services covering disease prevention, health promotion, treatment, rehabilitation and palliative care. Includes standards to ensure access, safety, quality, effectiveness and accountability.</td>
<td>Essential medicines and technologies: universal access to health services is not possible without policies to assure affordable access to essential medicines, vaccines and health technologies. Includes a national list of essential medicines, an effective distribution system for essential medicines and health technologies, and a regulatory system for marketing authorization, and for the monitoring of medicines and therapeutic products.</td>
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The right to health, as explained in General Comment 14, does not create an entitlement to be healthy. Nor does it hold States responsible for all the potential causes of poor health, including genetic susceptibility or an individual’s choice to adopt an unhealthy lifestyle. On the other hand, the
obligation to respect, protect, and fulfil the right to health places health on the agenda of every government, and provides a mandate for the legislative and administrative actions that are necessary, across all the relevant sectors of government, to create the conditions in which members of the population can realize the highest attainable standard of health. The right to health provides an over-arching and exacting standard to guide the actions of governments as they seek to strengthen their health systems, and to review the health impact of legislation and policies outside the health sector.

The right to health has inherent value for members of the population because it imposes on governments an obligation to help to create the conditions for a healthy, productive and flourishing life. However, in addition to its inherent value, there are at least two important reasons why the right to health – as a guiding value for the law reform process – is more likely to achieve the goal of longer and healthier lives.

Firstly, in some areas, including sexually transmissible infections, and contagious diseases (e.g. influenza), it is difficult if not impossible to effectively or efficiently monitor the behaviours that result in disease transmission. As a result, the extent of disease transmission will depend, to a significant degree, on the voluntary cooperation of individuals. In the case of pandemic or infectious diseases, people are more likely to trust the advice of governments, and to follow lawful directions, if they are confident that they will be treated fairly and in accordance with the rule of law. Laws that take account of the impact of government actions on all members of the population, including those who are marginalized and powerless, are likely to be most effective in minimizing disease transmission. For example, in the case of sexually transmissible infections, individuals are more likely to present for treatment and to follow medical advice if the law protects them from discrimination by health professionals and other service providers.

The second reason why the protection of human rights is central to the effectiveness of public health law is because, in circumstances where human rights are ignored or disregarded, significant sections of the population risk being marginalized. If this happens, their health will suffer, and this, in turn, will defeat the universal goal towards which the right to health aspires: to create the conditions for the highest attainable standard of health across the whole population. In most societies, distinct patterns of health inequality correlate with socioeconomic status and undermine the achievement of other social and economic goals. If countries are to make progress towards realizing the right to health for their populations, they must address the broad range of social, economic and environmental factors that are responsible for health inequalities.

1.2 Concepts and principles for guiding and evaluating law reform efforts

Governments owe a duty to ensure that health care facilities, goods and services, as well as public health services, facilities and programmes, are available, accessible, culturally acceptable, scientifically and medically appropriate and of good quality. These principles, which are discussed further below, can be used by governments and other stakeholders both to evaluate the adequacy of existing laws and to determine the scope of needed reforms.
(a) The goal of universal health coverage

The principles of availability, accessibility, acceptability and quality are not only guiding concepts that help to clarify the nature of the responsibility that governments owe under the right to health. They also highlight actions to be taken to achieve the goal of universal health coverage (UHC) (Box 1.4). UHC, in turn, is a way of making progress towards meeting the various treaty obligations that countries have undertaken regarding the right to health. 38

UHC has been defined as “all people receiving quality health services that meet their needs without exposing them to financial hardship in paying for them”. 39 The priority health services referred to in this definition include promotive, preventive, curative, rehabilitative and palliative health services. 40 Defined in this way, the objectives of UHC are: equitable access to priority health services (health for all), quality and effectiveness of health services, and financial protection. Like the concept of a health system (Table 1.1), UHC includes but is not limited to affordable access to health care services; it extends to public policies and actions taken outside the health sector to address the determinants of health. 41

Box 1.4: The concept of UHC

In December 2012, the United Nations General Assembly reaffirmed the goal of UHC, pointing out that the concept implies that:

all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative and rehabilitative basic health services and essential, safe, affordable, effective and quality medicines, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor, vulnerable and marginalized segments of the population. 42

UHC is typically presented as a cube (the “UHC cube”) with three dimensions or axes representing the population, health services, and health costs (Figure 1.1). The x axis represents the population, and shows the proportion of the population who are covered, and who are not covered, by a funding mechanism created from pooled funds.
Figure 1.1: The UHC cube: services provided, people covered, and cost

The z or services axis represents the range of services that are provided from pooled funds, as a proportion of the full set of quality health services that the population needs. The services axis encompasses all levels of the health system, including health care services provided to individuals in the primary care setting, and in hospitals, preventive services provided in community settings, as well as public policies and laws addressing health risks at the population level, such as taxes on alcohol and bans on the advertising of tobacco. Since it encompasses priority health care services, the services axis encompasses universal access to essential medicines and technologies, a motivated and effective health workforce, and health information systems. Since it encompasses preventive services, the services axis includes immunizations, the provision of family planning and pregnancy care services, water and sanitation infrastructure, regulatory frameworks for a safe and sustainable food supply, and for controlling epidemics of infectious disease, as well as laboratories and other infrastructure for monitoring health risks.

The y axis relates to the cost and affordability of the services provided. It illustrates the proportion of health costs that are met from pooled funds, and the proportion of health costs that impose direct costs on individuals and families, as a proportion of the total cost of providing the population with the health services that it needs. In low- and middle-income countries, health services may be funded in a variety of ways, including through taxes (services provided or funded by government), through pre-payment systems (insurance), through direct payments by individuals, and in some cases through donor contributions. Since the poor may be unable to meet user fees, or may suffer financial hardship in doing so, taxes and insurance systems are vital to increasing health equity.
Pooled funds can reduce health inequalities by increasing the affordability of health costs, as well as the number of services that do not impose direct costs on users.

The UHC cube represents a dynamic system. The population axis will continue to expand as the population grows; the services axis will expand as new health services, treatments, drugs and technologies become available, while the cost axis will expand as treatments and other services become more expensive to provide.\(^4^4\)

The purpose of the UHC cube is to encourage countries to expand the provision of priority health services, to extend the coverage of those services to more people, and to reduce out-of-pocket payments.\(^4^5\) This raises critical questions, including which new services to include in the benefits package (services axis), which services to expand to a wider proportion of the population, how to define the eligibility criteria for coverage (population axis), and how to finance the expanded range of services covered by pre-payment mechanisms (cost axis). Increasing coverage requires an understanding of the bottlenecks and weaknesses that prevent health systems from serving the entire population and from providing the full suite of priority services at a cost that is affordable and sustainable. As explained below, the guiding concepts of availability, accessibility, acceptability, and quality focus attention on each of the axes of the UHC cube, and provide a framework for evaluating the actions taken by governments to expand UHC.

**(b) Availability**

General Comment 14 emphasized that health care facilities, goods and services, as well as public health services, facilities and programmes should be available in sufficient quantity.\(^4^6\) The precise nature of the facilities, goods, and services will vary according to many factors, including the level of development of each country, the unique set of health challenges it is facing, the available sources of financing and the mix of public and private sector service providers. Nevertheless, services, facilities and programmes that are essential to an effective health system include: sources of safe and potable drinking water, adequate sanitation facilities, health clinics, hospitals and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.\(^4^7\)

Right to health concepts provide a helpful way of evaluating efforts to move towards UHC. The guiding principle of availability links with the services axis of the UHC cube (**Figure 1.2**). It requires governments to assess health needs within the population, and to address the constraints and barriers to scaling up the provision of priority services to meet those needs. In many cases, these constraints will reflect weaknesses in the building blocks of the health system (**Table 1.1**), including lack of investment in the resources that are necessary to provide the appropriate quantity or volume of services. Common problems may include:

- lack of facilities and infrastructure (including bad roads or transport options to enable people to travel to places where they can register for insurance coverage or receive health services);
- inadequate distribution systems for essential medicines;
• lack of human resources (a skilled and motivated health workforce – especially in rural and remote areas);

• lack of planning and leadership, and

• the absence of legislative and governance frameworks for managing the provision of services and for ensuring accountability.

Improving availability requires more investment in the resources that make it possible to increase the range of health services that can be delivered to the population (i.e. more services), as well as the maximum capacity of those services (more of each service).\textsuperscript{49}

**Figure 1.2: Evaluating progress towards UHC using right to health concepts**

The commitment of governments and other service providers to increasing the availability of health services may be formalized through technical, financial and logistic plans, with assistance from development partners, as appropriate. However, law reform is an important and often unacknowledged part of the governance reforms that are necessary to implement health plans, to scale up the delivery of health services, and to manage resources effectively. For example, legislation may be needed to establish a health insurance commission to manage a national health insurance scheme, including registering members, accrediting health service providers, processing claims and managing a national health insurance fund. Similarly, legislation may be needed to establish a national medicines authority to monitor the availability of essential medicines at affordable prices, to encourage the appropriate use of generic medicines, and to recommend the reduction of taxes, tariffs and mark-ups on essential medicines.\textsuperscript{50} Legislation may also establish systems for licensing
health care establishments, and training and registering classes of health professional that are adapted to each country’s particular needs.

Governments may formalize their commitment to improving the availability of health care and public health services through legislation establishing a national health system. For example, South Africa’s National Health Act seeks to implement the constitutional right to access health care services, and other health-related rights, by establishing a national health system which provides the population with the best health services that available resources can afford, in an equitable manner (Box 1.5). Ultimately, the guiding principle of availability directs attention to the capacity of governments to provide more services from pooled funds and to increase the volume of the services that are offered.

Box 1.5: The goals of South Africa’s National Health Act (Act no. 61 of 2003)

2. Objects of the Act

The objects of this Act are to regulate national health and to provide uniformity in respect of health services across the nation by:

a) Establishing a national health system which:
   i) encompasses public and private providers of health services; and
   ii) provides in an equitable manner the population of the Republic with the best possible health services that available resources can afford;

b) Setting out the rights and duties of health care providers, health workers, health establishments and users; and

c) Protecting, respecting, promoting and fulfilling the rights of:
   i) the people of South Africa to the progressive realization of the constitutional right of access to health care services, including reproductive health care;
   ii) the people of South Africa to an environment that is not harmful to their health or well-being;
   iii) children to basic nutrition and basic health care services contemplated in section 28(l)(c) of the Constitution; and
   iv) vulnerable groups such as women, children, older persons and persons with disabilities.

(c) Accessibility

In addition to investing in the resources that are needed to ensure that health facilities, goods and services are more widely available, governments must take steps to ensure that these services are accessible to the entire population. The concept of accessibility has four overlapping dimensions: non-discrimination, physical accessibility, affordability and information accessibility.
Non-discrimination

The guiding principle of non-discrimination relates to the population axis of the UHC cube, since the goal of protecting people from discrimination is to ensure that they are not excluded from receiving the health services that they need (Figure 1.2). Members of the population should not be denied access to health services or medicines because of their racial or cultural identity, their sex, language or religion, their physical or mental disability, sexual orientation, political opinions, or their health status (including HIV status). Discrimination entrenches health inequalities by excluding marginalized and vulnerable groups and by treating them less favourably than other individuals and groups. For example, some countries have large, permanent populations of migrants who provide a cheap labour force and may live for many years in the country without gaining citizenship. If governments are to create the conditions in which all members of the population can realize the highest attainable standard of health, then public health and health care services must also be accessible by these populations.

General Comment 14 states that countries have an immediate obligation to respect the right to health by preventing discrimination in access to curative, palliative and preventive services. Governments can honour these entitlements by passing and enforcing non-discrimination laws. Typically, these laws will set out the grounds of prohibited discrimination, or the protected attributes or characteristics that cannot lawfully be used as a basis for discriminating against a person in the provision of health services, employment and education, and in other areas. These laws may also establish a complaints-handling body with power to investigate and conciliate complaints, and to pursue other remedies in appropriate cases.

Physical accessibility

The guiding principle of physical accessibility also links with the population axis, by directing attention to the barriers and obstacles that stand in the way of extending health services to more people (Figure 1.2). Health facilities, goods and services will not contribute to the goal of improving public health unless they are within the safe physical reach of those who could benefit from them, including vulnerable or marginalized groups and others who have difficulty accessing services. These may include ethnic or religious minorities, indigenous populations, women, children, the elderly, people with disabilities, and people living in slums or in remote or inaccessible locations.

For example, remote populations will effectively be denied access to health services unless the infrastructure exists to enable them to reach and to use those services. Physical accessibility therefore includes not only physical infrastructure, such as adequate roads and bridges, but also forms of transport, such as bus or ferry services, and other forms of needed assistance, such as child care or disability support services.
Economic accessibility (affordability)

The guiding principle of economic accessibility directs attention to the cost axis (Figure 1.2). Essential health facilities, goods and services should be affordable for all. In many countries, health services are delivered through a mix of government, government-funded and privately-funded providers. Payment for health care services (including consultations, diagnostic procedures, and essential medicines), public health services (such as vaccinations), and services related to the underlying determinants of health (such as water, sanitation and the removal of rubbish), should be based on the principle of equity. This requires that these services should be affordable to everyone, including socially and economically disadvantaged groups, those with no fixed income, or with precarious incomes working in the informal sector. Box 1.6 provides an example of how law can formalize a national government’s commitment to keeping health services affordable.

Economic accessibility requires governments to implement funding mechanisms that reduce out-of-pocket payments imposed at the time the service is delivered, while expanding revenues obtained through taxpayer funded health insurance schemes, premiums or other pre-payment mechanisms. By increasing the proportion of health services that are funded from pooled funds, governments can reduce the proportion of the population who suffer catastrophic out-of-pocket expenditures, or who defer or are denied services due to their inability to pay.

Box 1.6: Improving economic access to health care services in the Islamic Republic of Iran


Article 90 of the Plan was intended to enhance fairness in accessibility to health care services by reducing the proportion of low-income households suffering from catastrophic expenditure on health (that is, expenditures consuming more than 40% of income after basic subsistence needs have been met). Article 90 directed the Ministry of Health, Medicare and Medical Education to prepare by-laws ensuring that out-of-pocket payments (the contribution of patients to the costs of health care services) do not exceed 30% of the total cost of those services. The goal of Article 90 is also to reduce the proportion of vulnerable households suffering from catastrophic health care expenditures to 1%.

Economic accessibility does not mean that all services should be provided by government, nor that services should be made available to all individuals free of charge. However, it does require governments to take concrete steps to ensure that the poorest and most vulnerable groups in society are not “disproportionately burdened with health expenses as compared to richer households”. For example, this may require government to subsidize the costs of health services in remote and rural areas, where the provision of those services is necessarily less cost-effective, and where the true cost of those services would put them out of reach of poorer, vulnerable groups.
Information accessibility

The principle of accessibility includes the right to seek, to receive and to express information and ideas about health issues to others. Health service providers and health insurance schemes must also ensure that personal health data is kept secure, and that privacy and confidentiality are respected. Both of these aspects of information accessibility relate to the population axis, by directing attention to factors that may undermine demand for health services in the population (Figure 1.2).

Protecting the confidentiality of each person’s health care information is necessary to create trust and to encourage all members of the population to access health care services. Protecting the confidentiality of particularly sensitive information, such as information relating to HIV infection, sexual health or mental health, is especially important in order to avoid creating disincentives to people seeking information and treatment in these areas.

(d) Acceptability

The principle of acceptability provides that health facilities, goods and services should be delivered in ways that are culturally appropriate, sensitive to gender and to different age groups, and consistent with ethical obligations. Acceptability relates to the population axis, by directing attention to factors that may undermine demand for health services by those who need them. For example, there is good evidence that providing clean needles and syringes to persons who are injecting drug users will reduce the transmission of HIV.\(^5\)\(^8\) However, clean needles must be available in trusted locations where injecting drug users feel safe in accessing them (such as outreach centres, vans, trust points), without the risk of harassment, arrest or criminal liability. Legislation which criminalizes the possession of needles and syringes can undermine efforts to reduce HIV transmission among injecting drug users.

(e) Quality

Health facilities, goods and services should be scientifically and medically appropriate and of good quality. Ensuring quality in the provision of facilities, goods and services requires a skilled health workforce, processes for assuring the supply of officially approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

Quality is an independent variable that is central to the capacity of governments to move towards UHC.\(^5\)\(^9\) Unless the health services that governments provide are effective, and of high quality, they cannot contribute to the realization of the highest attainable standard of health. In addition, quality is relevant to the population axis of the UHC model (Figure 1.2): if health services are of poor quality, this may reduce demand for those services, even by those who need them.
REFERENCES


14 Council of Europe, European Social Charter (revised) ETS 163 (entered into force 1 July 1999), Article 11.


17 Constitution of the Republic of South Africa, Act 108 of 1996 (South Africa), ss 27(1)(a), (b) and (c), 28(1)(c) and 35(2)(e).

18 Constitution of the People’s Republic of Mongolia 1992 (Mongolia), Article 16.


1 All references were accessed on 1 May 2016.


PART 2
THE PROCESS OF PUBLIC HEALTH LAW REFORM