

Submission to Office of the United Nations High Commissioner for Human Rights in response to the ‘Call for Contributions: Example of a Human Rights-Based Approach to Universal Health Coverage’

3 April 2023

The Global Initiative for Economic, Social and Cultural Rights (GI-ESCR) welcomes the call for contributions of the United Nations High Commissioner for Human Rights (OHCHR) in relation to its upcoming policy brief on realising Universal Health Coverage (UHC).

The submission seeks to answer question 1 of the questionnaire. It focuses on the centrality of public healthcare provision and financing for the realisation of UHC in line with the right to health, which includes the entitlement to access universal healthcare services under international human rights law. At the same time, it highlights the risks of shifting healthcare financing and provision from the public onto the private sphere and highlights the potential negative human rights implications of overreliance on the concept of UHC for the realisation of the right to health. The submission warns that UHC should not become a substitute or a synonym for realising the right to health in health policy and global health narratives. In this regard, it emphasises that the right to health translates into a specific set of binding legal obligations for states that is not reflected in the UHC framework.

1. UHC policies and programs that explicitly prioritize health care access and financial protection for populations that are most left behind.

Public healthcare services are essential to realise the right to health. In line with Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) everyone has the right to public healthcare services that are available, accessible, acceptable, high-quality, and non-discriminatory.¹

The United Nations Committee on Economic, Social and Cultural Rights (CESCR) and the Committee on the Rights of the Child (CRC) have both called on specific States to provide public services and public healthcare.² Looking at the African context, in 2019, the African Commission on Human and Peoples’ Rights, affirmed the role of African States in being ‘the duty bearers for the protection and fulfilment of economic, social and cultural rights, in particular the rights to health and education without discrimination, for which quality public services are essential’.³

¹ International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 999 UNTS 3 (ICESCR) Art. 12. CESCR, ‘General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant)’ (11 August 2000) E/C.12/2000/4, para. 32.

² GI-ESCR, ‘Compendium of United Nations Human Rights Treaty Bodies’ Statements on Private Actors in Healthcare’ (June 2021) <https://www.gi-escr.org/publications/compendium-of-united-nations-human-rights-treaty-bodies-state-ments-on-private-actors-in-healthcare>. Accessed March 2023.

³ African Commission on Human and Peoples’ Rights, ‘Resolution on States’ Obligation to Regulate Private Actors Involved in the Provision of Health and Education Services’ (2019) Res. 420 (LXIV) <https://www.achpr.org/sessions/resolutions?id=444>. Accessed 14 March 2022.

Thus, UHC programs and policies that prioritise the right to health must include public healthcare services at their core.⁴ Moreover, while UHC has been termed as a ‘practical expression of the right to health’,⁵ we advise being extremely careful with this overlap.⁶ Not only the right to health is much broader than UHC, encompassing the underlying determinants of health. Dainius Puras, the former special rapporteur on the right to health, has highlighted that healthcare systems and UHC programs must always incorporate the human rights principles of equality and non-discrimination, transparency, accountability, and participation⁷, as well as the cross-cutting dimensions of access to information and participation.

Even when it comes to healthcare services and coverage, not all pathways to expand UHC are consistent with international human rights law. Chapman suggested that, for achieving UHC in line with international human rights law, some criteria must be respected, such as that states have to make access to essential services a legal entitlement, including providing adequate access to redress and remedies; and they have to implement a progressive and equitable system of health funding for financial protection in health, targeting the removal or amelioration of financial barriers to healthcare, especially for marginalised groups and those living in conditions of material deprivation. He has also reminded that at least 5% of the gross domestic product and 15% of the total government budget should be devoted to the strengthening of health systems and expand universal access to healthcare;⁸ and that an effective data monitoring system, including disaggregated data, is put in place to evaluate the distributional effects of UHC programs.⁹

Freeman and others have studied an interesting example of an Aboriginal community-controlled health service in Australia that is universal, rights-based, publicly funded comprehensive primary healthcare.¹⁰ Below, we provide further examples from Kenya and Nigeria.

In Kenya, the right to health is protected by the Constitution and regional and international human rights treaties.¹¹ In this context, public healthcare services have been central in advancing the

⁴ Abihiro, Gilbert Abotsem and Manuela De Allegri (2015) ‘Universal Health Coverage from Multiple Perspectives: A Synthesis of Conceptual Literature and Global Debates’, *BMC International Health and Human Rights* 15, 1(17).

⁵ WHO, (2013) *Positioning health in the post-2015 development agenda*. Geneva: World Health Organization.

⁶ Audrey Chapman (2016) ‘The Contributions of Human Rights to Universal Health Coverage’, *Health and Human Rights Journal* 18(2).

⁷ Dainius Puras, (2016) ‘Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health to the UN General Assembly on the 2030 Agenda for Sustainable Development and the Sustainable Development Goals’, UN Doc. A/71/150. para. 17.

⁸ *Ibid.*

⁹ Audrey Chapman (2016), see note 6.

¹⁰ Toby Freeman and others, (2016) ‘Case Study of an Aboriginal Community-Controlled Health Service in Australia: Universal, Rights-Based, Publicly Funded Comprehensive Primary Health Care in Action’, *Health and Human Rights Journal* 18(2).

¹¹ Constitution of Kenya (2010); African Charter on Human and Peoples’ Rights (adopted 27 June 1981, entered into force 21 October 1986) (1982) 21 ILM 58 (African Charter, ratified in Kenya in 1992).

target of UHC. In 2018, the public healthcare service accounted for 58% of outpatient visits and 50% of inpatient admissions,¹² of which is more than for-profit, non-profit, and faith-based actors combined.¹³ The public healthcare sector offers a comprehensive package of medical services, including prevention, public health promotion and promotive care, employing highly qualified workers.

Kenyan public healthcare services are also more accessible to low-income groups than private facilities. For instance, a study found that, across a wide range of non-communicable disease treatments, private health facilities charge higher fees than public facilities for the same service.¹⁴ Likewise, a 2019 quantitative analysis found that the private sector mainly serves the richest segment of the population, while public services deliver medical care to a much wider share of individuals from a low socio-economic background.¹⁵ This reflects the fact that formal, high-end private healthcare facilities are concentrated in wealthy urban areas and target upper-income patients,¹⁶ while public services are generally more spatially widespread and include completely free services at public centres and dispensaries (i.e. facilities of level 2-3 in Kenya's health system).¹⁷

Several policy developments in public healthcare facilities shows beneficial effects on the right to health and UHC. In 2004, user fees at lower-level public facilities were replaced with modest registration fees. Also, services for children under five and treatment for a range of critical conditions were exempted from payment. This was correlated with a spike in healthcare use at 70

¹² Kenyan Ministry of Health (2018) *Household Health Expenditure and Utilization Survey*, pp. 27, 42.

¹³ Hakijami and the Centre for Human Rights and Global Justice of New York University, 'Wrong Prescriptions: the Impact of Privatising Healthcare in Kenya' (November 2021). Available at: https://chrgj.org/wp-content/uploads/2021/11/Report_Wrong-Pre-scription_Eng_.pdf. Accessed March 2023.

¹⁴ Sujha Subramanian and others, (2018) 'Cost and Affordability of Non-Communicable Disease Screening, Diagnosis and Treatment in Kenya: Patient Payments in the Private and Public Sectors' *Plos One*.

¹⁵ Stefania Ilinca and others (2019) 'Socio-Economic Inequality and Inequity in Use of Health Care Services in Kenya: Evidence from the Fourth Kenya Household Health Expenditure and Utilization Survey' *International Journal for Equity in Health*, 18(196).

¹⁶ Kenya Institute for Public Policy Analysis (2004) 'A review of the Regulatory Framework for Private Healthcare Services in Kenya' https://pdf.usaid.gov/pdf_docs/pnads076.pdf. Accessed March 2023.

¹⁷ Global Initiative for Economic, Social and Cultural Rights (GI-ESCR), (2021) Patients or Customers? The impact of Commercialised Healthcare on the Right to Health in Kenya during the COVID-19 pandemic. available at: <https://www.gi-escr.org/publications/patients-or-customers-the-impact-of-commercialised-healthcare-on-the-right-to-health-during-the-covid-19-pandemic-in-kenya>. Accessed April 2023.

per cent higher than before.¹⁸ Similarly, when user fees in public dispensaries were abolished in health centres in 2013, healthcare use rose by 37% for all patients over five years of age.¹⁹

More recently, the pilot phase of UHC entailed removing user fees at public facilities for healthcare services in four Kenyan counties in 2018 and 2019. This led to increased use of healthcare services and treatments.²⁰ A report found that in the county of Isiolo, one of the UHC pilot areas, interviewees offered exceptionally strong praise for the public program, highlighting the value of the public system. Community members, healthcare volunteers, and healthcare workers reported that the public services ensured access to previously unaffordable specialist care and drugs regardless of wealth.²¹ Similarly, some county authorities are undertaking programs to improve access to public healthcare. For example, Nairobi Metropolitan Services recently constructed six new health facilities that treated more than 70,000 patients between March and June 2021.²²

Public healthcare services are thus achieving remarkable results for the right to health, including universal health coverage targets. This despite the fact that they are starved with resources; domestic spending on health was as low as 9% of the national budget in 2020,²³ far below the target of 15% to which the African Union States committed in the Abuja Declaration.²⁴ The lack of resources means that there are not enough public healthcare services for all in Kenya. Strengthening public healthcare systems is the most viable solution to improve UHC for all, in line with international human rights standards.

In Nigeria, the 1999 Constitution guarantees a right to 'adequate medical and health facilities for all persons'.²⁵ While this provision is contained in a section of the Constitution that is non-justiciable, the right to health in Nigeria can be brought to court indirectly through the right to life.²⁶ Nigeria is

¹⁸ Jane Chuma and Thomas Maina, *Free Maternal Care and Removal of User Fees at Primary-Level Facilities in Kenya: Monitoring the Implementation and Impact: Baseline Report* (Washington, D.C.: Health Policy Project. Available at: https://www.healthpolicyproject.com/pubs/400_KenyaUserFeesBaselineReportFINAL.pdf. Accessed March 2023.

¹⁹ Derrick Okubasu, '830K People Stranded as Governor Scraps Uhuru's Free Healthcare Project', *Kenya.co.ke* (August 2020). Available at: <https://www.kenya.co.ke/news/56765-830k-people-stranded-governor-scraps-uhurus-free-healthcare-project>. Accessed March 2023.

²⁰ Ibid.

²¹ Hakijami (2021) see note 13.

²² Ibid.

²³ Ibid.

²⁴ WHO, (2011) *The Abuja Declaration: Ten Years On* (2011). Available at: <https://apps.who.int/iris/bitstream/handle/10665/341162/WHO-HSS-HSF-2010.01-eng.pdf?sequence=1>. Accessed April 2023.

²⁵ Constitution of Nigeria (1999 amended in 2011) section 17(3)(d).

²⁶ Remigius Nwabueze, 'The Legal Protection and Enforcement of Health Rights in Nigeria' in Colleen M Flood and Aeyal Gross (eds), *The Right to Health at the Public/Private Divide: A Global Comparative Study* (Cambridge University Press 2014).

also a party to the African Charter on Human and People's Rights (ratified in 1983), which protect the right to health in Article 16 and that has been domesticated into Nigerian law.²⁷

In this context, public healthcare services are essential in realising the right to health and universal health coverage targets in Nigeria. Public healthcare services are more accessible to low- and middle-income groups in comparison to formally registered private providers both in geographical and financial terms.²⁸ The wealthier Southern regions have considerably higher concentrations of private healthcare providers. The highest peaks are in the large urban centres of Lagos (80%) and Imo (43%).²⁹ By contrast, private health actors are far less present in the poorer North, with percentages as low as 3% in Yobe.³⁰ This suggests that formally registered private health providers, which might also be of higher quality, tend to concentrate their operations where profit chances are higher.³¹ This dynamic has been observed in other sectors and countries, such as education in Morocco and Ghana.³²

The two-tier unequal health system in Nigeria is not only visible in the unequal access to formal private facilities, but also through the differential access to the public system. As a survey by the WHO shows,³³ people from disadvantaged socioeconomic groups look for medical assistance in public facilities relatively more than the well-off.³⁴ An explanation for this dynamic might be the difference in healthcare costs: the National Health Policy (2016) mentions the 'unaffordability of services provided by the private sector to the poor' as one of the main challenges within Nigeria's healthcare system.³⁵

For more information, please consult the following publications:

- [The Future is Public: Global Manifesto for Public Services](#) (2021).

²⁷ African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act, 1990.

²⁸ Global Initiative for Economic, Social and Cultural Rights (March 2022) 'The right to health during COVID-19 in Nigeria. Discrimination and inequality in a Commercialised Healthcare System'. Available at: <https://gi-escr.org/en/resources/publications/report-the-right-to-health-during-covid-19-in-nigeria>. Accessed April 2023.

²⁹ Ibid. p. 29.

³⁰ Ibid.

³¹ Zuhumnan Dapel, 'Poverty in Nigeria: Understanding and Bridging the Divide between North and South' *Center for Global Development* (6 April 2018). Available at: <https://www.cgdev.org/blog/poverty-nigeria-understanding-and-bridging-divide-between-north-and-south>. Accessed April 2023.

³² GI-ESCR, The UN asks Ghana to explain itself on privatisation (24 October 2021) <https://www.gi-escr.org/latest-news/the-un-asks-ghana-to-explain-itself-on-privatisation-in-education>. Accessed March 2023.

³³ WHO Global Health Observatory data, <https://www.who.int/data/gho>. The survey is available here: <https://www.who.int/data/gho/data/themes/topics/indicator-groups/sources-of-care-in-mixed-health-systems>.

³⁴ GI-ESCR (2022), see note 25, p. 30.

³⁵ Nigerian Federal Ministry of Health, Revised National Health Policy (2016). Available at: https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/nigeria/draft_nigeria_national_health_policy_final_december_fmoh_edited.pdf. Accessed April 2023.



- [Santiago Declaration](#) (2022).
- Global Initiative for Economic, Social and Cultural Rights, '[Compendium of United Nations Human Rights Treaty Bodies' Statements on Private Actors in Healthcare](#)' (June 2021).
- Global Initiative for Economic, Social and Cultural Rights, '[States' Human Rights Obligations regarding public services essential for the enjoyment of Economic, Social and Cultural Rights – The regional perspective](#)' (September 2022).
- Global Initiative for Economic, Social and Cultural Rights and Justice & Empowerment Initiative (2022) '[The failure of commercialised healthcare in Nigeria during the COVID-19 pandemic. Discrimination and inequality in the enjoyment of the right to health](#)'.
- Global Initiative for Economic, Social and Cultural Rights, '[Patients or Customers? The impact of Commercialised Healthcare on the Right to Health in Kenya during the COVID-19 pandemic](#)' (2022)
- New York University and Hakijami, '[Wrong Prescriptions: the Impacts of Privatising Healthcare in Kenya](#)' (2022)
- [Principles for Human Rights in Fiscal Policy](#) (2022).
- Global Initiative for Economic, Social and Cultural Rights, '[Italy's Experience during COVID-19: the Limits of Privatisation in Healthcare](#)' (2 June 2021).

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