Reviewer's report

Title: Is universal health coverage the practical expression of the right to health?

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Reviewer: Lauren Paremoer

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Minor Essential Revisions

The article is a welcome addition to the literature on global health and justice. It lays out a convincing argument that the “super-norm” of universal health coverage (UHC) can contribute to the realisation of the right to health care, provided that states cooperate in order to advance this goal. I think the argument can be clarified and strengthened by considering the following revisions:

1. Title: The right to health vs. health care

The title of the paper does not accurately reflect the authors’ analytical focus. The title suggests that the right to health is main focus of the paper. However, as the authors acknowledge in the “Background” section, the paper evaluates the extent to which UHC contributes to realising the right to health care. This distinction is important as the right to health goes beyond providing universal access to health care, as the authors themselves acknowledge.

2. Conclusion: The right to health vs. health care

Throughout the paper the authors emphasise that the right to health is distinct from the right to health care, that UHC is a mechanism that promotes the right to health care, and that they “limit the scope of their …analysis to health care”. It is worth noting that the authors lose sight of the distinction between the rights to “health” vs. “health care” in the final two paragraphs of their paper.

The second last paragraph discusses a UN Sustainable Development Solutions Network (UNSDSN) document which sets out a framework for financing UHC in developing and developed states. The final paragraph concludes that this financing framework will enable a version of UHC that is tantamount to the “practical expression of the right to health”. This contradicts the authors’ assertions earlier on in the paper that UHC cannot be regarded as a mechanism that “practically express[es] the right to health in totality”. In order to ensure the argument remains consistent throughout, I suggest that the final sentence in abstract, as well as the final sentence in the body of the paper, be amended to refer to the right to “health care”.

Discretionary Revisions
3. Justifying claims regarding the efficacy of UHC in realising the right to health care

3a. The harmful effects of vertical programmes

In the “Discussion” section the authors mention that UHC proposes a package of reforms that is more extensive than MDGs4-6 and that these reforms “would arguably [sic] move closer to the right to health”. I agree with the observation that comprehensive reforms are more desirable because they benefit greater numbers of people (as argued by the authors). In support of the claim that comprehensive reforms are more desirable than vertical interventions, it may also be worth referencing literature which suggests that vertical public health programmes, particularly those aimed at eradicating specific diseases, may undermine the strength, efficacy and coherence of public health systems. In doing so, these programmes arguably undermine the capacity of states to meet the overall public health needs of their populations.

3b. Discuss the risks of external funding/donor-driven health programmes

Empirical research suggests that donor-driven health interventions may have negative spill-over effects on national public health systems. Throughout the paper the authors argue (correctly, I my opinion) that international assistance is crucial to realising UHC in developing states. However they treat international assistance as an unambiguously good thing, i.e. external funding is framed as if it is always an expression of international solidarity.

The authors fail to take account of the fact that international assistance may also be an expression of the political and financial interests of donors/funders. I think the argument would benefit from a brief discussion of this point. External funding has the potential to distort the health priorities and practices of developing states. Acknowledging this dimension of international assistance is particularly important given the authors’ admission that discussions about UHC have not been “straightforward” in their commitment to defending the importance of preserving “participatory decision-making” in the health sector (see the section entitled “Comparing the right to health care with universal health coverage”).

4. Authoritative Sources: The Alma Ata Declaration’s conception of the right to health

On the whole, the “authoritative sources” that appear in the text have been well chosen. However, I think the Alma Ata Declaration could also have been included as an “authoritative source” in defining the “right to health”. The declaration enjoyed broad-based political support when it was first adopted and continues to inform recent efforts to expand access to primary health care services, including sophisticated curative services such as highly active antiretroviral treatment, in the developing world.

Including this text has important implications for how the principle of “shared responsibility” in promoting the rights to health and health care is understood.
Like the ICESER, the Alma Ata declaration argues that states should cooperate in order to realise the rights to health and health care. Both documents argue that technical cooperation and international assistance are essential to realising these rights. However, unlike the ICESER the Alma Ata declaration emphasises that these forms of international assistance cannot address one of the root causes of poor health outcomes in the developing world: The international “economic order”.

The Alma Ata declaration identifies the international trade and financial systems, legal regimes for managing the ownership and distribution of technology, and the legacy of colonialism and imperial rule, as root causes of the concentration of poor health outcomes in developing vs. developed countries, and amongst the poor vs. the rich in all countries. As explained in the Alma Ata declaration, the right to health is thus contingent upon the creation of a global economic system that improves the social determinants of health worldwide, and eliminates systematic inequalities in the distribution of the determinants of health. It therefore sets out a principle of shared responsibility that couples international assistance with coordinated international efforts to create a “New International Economic Order” (NIEO) which creates a more equitable global economy.

Given that the article does not use the Alma Ata declaration as a reference point, this imperative to bring about fairer systems of trade, production and finance is not included in the discussion of international cooperation or in the conception of the right to health. In doing so, the paper ignores an important historical reference point that has shaped conceptions of the right to health and debates about how it should be achieved. The oversight also means that the authors’ conception of how states should cooperate in order to advance the right to health care is fairly narrow. The paper defines shared responsibility exclusively in terms of technical cooperation and financial assistance, and fails to discuss the systemic reforms states could undertake in the name of their “shared responsibility” to realise the right to health care. This could include coordinated international efforts to create trade laws that are explicitly designed to improve access to essential medicines (e.g. the TRIPS exceptions contained in the Doha Declaration), or efforts to incentivise firms to create new drugs based on the need for these medicines rather than their profitability (e.g. The Health Impact Fund).

**Level of interest:** An article of importance in its field

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I declare that I have no competing interests.