

What Do Core Obligations under the Right to Health Bring to Universal Health Coverage?

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Abstract

Can the right to health, and particularly the core obligations of states specified under this right, assist in formulating and implementing universal health coverage (UHC), now included in the post-2015 Sustainable Development Goals? In this paper, we examine how core obligations under the right to health could lead to a version of UHC that is likely to advance equity and rights. We first address the affinity between the right to health and UHC as evinced through changing definitions of UHC and the health domains that UHC explicitly covers. We then engage with relevant interpretations of the right to health, including core obligations. We turn to analyze what core obligations might bring to UHC, particularly in defining what and who is covered. Finally, we acknowledge some of the risks associated with both UHC and core obligations and consider potential avenues for mitigating these risks.

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Introduction

Can the right to health, and particularly the core obligations of states specified under this right, assist in formulating and implementing universal health coverage (UHC), now included in the post-2015 Sustainable Development Goals (SDGs)?¹ This question has driven research under the Go4Health Consortium, which seeks to embed rights-based approaches in the post-2015 SDG health agenda. The Go4Health Consortium, of which all authors are a part, focuses on what the right to health offers discursively and substantively to this agenda and aims to clarify the contributions of the core obligations that flow from the right to health.² Rights language frames health—not as an externality, investment, or issue of compassion but as a legal entitlement and fundamental matter of social justice.³ Thus, framing global health as a question of human rights guides our understanding of it, identifying the actors that must be engaged and the legally prescribed measures needed to achieve it.⁴ In this paper, we examine how core obligations under the right to health could lead to a version of UHC that is more likely to advance equity and rights. In adopting so specific a focus on core obligations and UHC, we do not intend to obscure or delegitimize important investigations of what the larger right to health canon brings to elaborating and implementing UHC. Indeed, the current authors have produced a significant amount of scholarship focused on this question, exploring what right-to-health components and mechanisms (such as progressive realization and indicators) bring to UHC.⁵ This paper adopts a far narrower focus on what core obligations might offer to UHC, since irrespective of their interpretive deficits and scholarly contestation, core obligations remain a fundamental component of contemporary interpretations of the right to health.⁶ To this extent, this analysis complements discussions of the right to health's broader contribution to formulating and implementing the SDGs.

To explore the question of what core obligations bring to UHC, we first address the affinity between the right to health and UHC as evinced through changing definitions of UHC and the health do-

main that UHC explicitly covers. We then engage with relevant interpretations of the right to health, including core obligations. We turn to analyze what core obligations might bring to UHC, particularly in defining what and who is covered. Finally, we acknowledge some of the risks associated with both UHC and core obligations and consider potential avenues for mitigating these risks.

UHC and the right to health

Given that the goal of UHC has strong synergies with the commitment to universalism enshrined within the right to health, UHC should be rooted explicitly within this right.⁷ This view is shared by the World Health Organization (WHO) and other institutional actors, who see UHC as a “practical expression of health equity and the right to health” and “deeply embedded” in international law.⁸ In 2012, the United Nations (UN) General Assembly endorsed this view when it called on states to realize UHC while reaffirming the right to health.⁹ More recently, WHO has expanded on this conception:

To support the goal of universal health coverage is also to express concern for equity and for honoring everyone's right to health. These are personal and moral choices regarding the kind of society that people wish to live in, taking universal coverage beyond the technicalities of health financing, public health and clinical care.¹⁰

However, at a practical level, what does the right to health imply for UHC, particularly regarding the crucial questions of the type of health care required to advance the right to health? This has been less clear, not least because of a lack of clarity around what is meant by UHC.¹¹

Changing definitions of UHC

The 2005 World Health Assembly resolution calling for UHC had a strong focus on financing and insurance (as its title suggests), defining UHC as “access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access.”¹²

It urged member states “to ensure that health-financing systems include a method for prepayment of financial contributions for health care, with a view to sharing risk among the population and avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking care.”¹³ The 2010 *World Health Report* did little to clarify the content of these services but brought the UHC cube, originally designed by Reinhard Busse et al., to a wide audience.¹⁴ The cube identified three key dimensions around which to measure progress toward UHC: the range of services available, the proportion of costs of services covered, and the proportion of the population covered. While the report acknowledged that funding constraints would mean “trade-offs between the proportions of the population to be covered, the range of services to be made available and the proportion of the total costs to be met,” it reiterated that UHC nonetheless meant that the “entire population in all these countries has the right to use a set of services (prevention, promotion, treatment and rehabilitation).”¹⁵

The UN General Assembly resolution in 2012 offered a fuller, multidimensional definition of UHC, requiring that

*[a]ll 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.*¹⁶

This resolution offered definitive UN member state political support for UHC, not only reaffirming, in explicit and detailed terms, everyone’s right to health but also recognizing “the responsibility of Governments to urgently and significantly scale up efforts to accelerate the transition towards universal access to affordable and quality health-care services.”¹⁷ This emphasis on non-discriminatory access to basic health services and essential medicines with a special focus on the poor, vulnerable, and marginalized indicates a clear commitment to human rights principles. Emphasizing non-dis-

criminatory access seeks to ensure that UHC does not simply lead to aggregate gains at the expense of the poor; at the same time, it is important to avoid the risk that an *exclusive* focus on the poor and vulnerable will lead to services that are selective—and thus potentially of poor quality—rather than comprehensive.¹⁸

This trajectory from key to basic to essential services is reflected in the somewhat terser final SDG 3.8 formulation, which commits states to “achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.” While the inclusion of UHC in the health SDG reflects a victory for its proponents, there are nonetheless questions about the priority accorded this target vis-à-vis the other nine targets associated with this goal. Moreover, the definition of UHC in the SDGs raises more questions than it answers: What does financial risk protection encompass? Can UHC be achieved through selective health care rather than comprehensive health system strengthening? And crucially, what should essential health care and medicines encompass? Due to space limitations, the remainder of this paper will focus on this last question alone.

What essential health care and medicines does UHC cover?

The health domains which UHC should cover are indicated in the remainder of the SDG health goal, where separate targets are specified for essential health care services. These include goals and targets in relation to maternal and child mortality, infectious and noncommunicable diseases, mental health, sexual and reproductive health, tobacco control and substance abuse, environmental pollution, health financing, and global health risk management.

These domains are fleshed out by the Inter-Agency Expert Group on SDG indicators (IAEG-SDGs), established by the United Nations Statistical Commission and tasked with proposing indicators for each SDG target.¹⁹ The IAEG-SDGs,

which is composed of member states along with agency observers, initially proposed two indicators for UHC: one to monitor coverage of tracer interventions (such as complete childhood immunization, antiretroviral therapy, TB treatment, hypertension treatment, and skilled birth attendance) and the other to monitor the portion of the population protected against catastrophic or impoverishing out-of-pocket health expenditures.²⁰ Perhaps reflecting the contentious nature of the UHC goal (SDG 3.8), in contrast to the other SDG 3 indicators these are the only indicators on which there was no general agreement within the IAEG-SDG team. The team classified the UHC indicators as requiring more in-depth discussion and methodological development. It is notable that the proposed SDG 3.8.2 indicator on catastrophic expenditure has now been replaced by one that aims to measure the number of individuals covered by health insurance or a public health system per 1,000 people.²¹ The new indicator has been critiqued for measuring aggregate outcomes and thus ignoring the kind of catastrophic and impoverishing expenditures addressed by the former indicator.²² It is anticipated that indicators, including SDG 3.8.2, will not be finalized until the UN Statistical Commission's March 2017 session.²³ Certainly, as currently formulated, SDG 3.8.2 would encourage models of UHC that provide selective interventions financed by insurance—an approach unlikely to improve equity in access or outcomes.²⁴

The “content” indicator covering tracer interventions is further specified in various domains of promotion, prevention, and treatment which will act as a global core subset of indicators that all countries are expected to implement.²⁵ Moreover, countries are expected to develop additional national indicators that reflect “their level of development, epidemiological situation, health system and people’s expectations” and that “cover promotion, prevention, treatment, rehabilitation and palliation.”²⁶ These tracer interventions appear to be based largely on a WHO and World Bank publication which proposes selecting tracer interventions according to the criteria of relevance, quality, and

availability. In relation to prevention services, the publication clarifies that

*six indicators are identified: satisfaction of family planning needs, at least four antenatal care visits, measles vaccination in children, improved water source, adequate sanitation and non-use of tobacco. For treatment services, another six indicators are identified for five areas of intervention: skilled birth attendance, antiretroviral therapy, tuberculosis case detection and treatment success (combined into a single indicator), hypertension treatment and diabetes treatment.*²⁷

However, in all of these cases, the selection of indicators appears to be driven by the ease of measurement and availability of data rather than by any clear conceptual or ethical framework. For example, an alternative approach might consider what data would be necessary under UHC grounded in the right to health.

The substantive content of core obligations under the right to health

There is obvious synergy between notions of universal access to affordable health services and the right to the highest attainable standard of health as entrenched in international law. We have previously identified key principles and imperatives stemming from the right to health that should guide the design of UHC:

- The inclusion of health care and the social determinants of health in the right to health;
- The emphasis on non-discrimination as a guiding principle and pragmatic arm of UHC;
- The imperative of participation and participatory decision making;
- The prioritization of vulnerable and marginalized groups;
- A focus on the principles of availability, accessibility, acceptability, and quality;
- Progressive realization;

- Core obligations;
- Shared responsibility and international assistance;
- Accountability;
- The framing influence of rights discourse; and
- Rights-based advocacy and litigation.²⁸

These principles assist in defining some of the more ambiguous and contentious aspects of UHC in relation to coverage/universality, services, and finances.

Furthermore, international human rights treaties provide some direction as to what health services should be covered under UHC anchored in the right to health. For instance, article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) indicates that for states to achieve the goal of the right to the highest attainable standard of physical and mental health, they must take steps to reduce infant mortality; improve environmental and industrial hygiene; prevent, treat, and control epidemic, endemic, occupational, and other diseases; and create conditions to assure medical services and attention in the event of sickness.²⁹ However, what the ICESCR's drafters meant by these steps was not specified at the time of their release. Moreover, much confusion ensued given that state duties under the ICESCR are limited to progressive realization within a maximum of available resources. Since article 12 did not specify what minimum or maximum level of health care satisfied the requirements of progressive realization within maximum available resources, member states ended up applying sometimes dramatically varying standards.

Subsequent authoritative interpretations of the right to health offer two helpful frameworks for assessing essential health care services. The first is the AAAQ framework, which reflects the idea that health facilities, goods, and services should be *available* in sufficient quantities; *accessible* physically, economically, and without discrimination; *acceptable* in medical, ethical, and cultural terms; and of good *quality*. The definition of accessibility is particularly relevant for considerations of

UHC since it includes non-discriminatory access, requiring inclusion of the most vulnerable and marginalized sections of the population. Discrimination is specified as extending to the prohibited grounds recognized in human rights law: race, color, 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. This principle underscores the importance of considering the needs of marginalized groups when implementing and monitoring UHC and in particular to disaggregate data according to the grounds just mentioned. Moreover, "economic accessibility" has significant implications for UHC, since it requires that services be equitable and affordable for all, including socially disadvantaged groups, whether these are privately or publicly provided.

The second and related way that the right to health helps define the content of UHC comes from the concept of core obligations developed by the UN Committee on Economic, Social and Cultural Rights. The committee introduced core obligations in order to limit the risk of governments unjustifiably invoking the principle of progressive realization (whereby achievement of the right to health might take time in light of limited resources) to deny health care or take very little action. Thus, the committee suggests that states hold "minimum core obligations" not subject to progressive realization or resource limitations, which ensures, at the very least, the fulfillment of minimum essential levels of each right.³⁰

The concept of core obligations has drawn considerable scholarly fire given that it is not explicitly referenced in the ICESCR text.³¹ We do not wish to re-litigate this point in great detail here, other than to mention that while it is true that the term "core obligations" does not appear in either the treaty text or drafting papers, several discussions during the treaty's drafting legitimate its later development. These include debates about the imperative of mitigating the risk posed by limitations of the right to health in the name of progressive realization under article 2, including through the elaboration

of minimum standards for ICESCR rights.³² More fundamentally, irrespective of its genealogy, the concept of core obligations has definitively entered legal interpretations of international social and economic rights, such as the right to health.³³ To this extent, we adopt a relatively positivist approach to the legitimacy of core obligations in our analysis of their potential contribution to UHC.

Much of the debate on core obligations arises from the committee's interpretation in General Comment No. 14 on the right to health, published in 2000. Here, the committee expands on its earlier suggestion that under the right to health, core obligations would include "essential primary health care."³⁴ In General Comment No. 14, the committee interprets core obligations under the right to health to include (1) ensuring non-discriminatory access to health facilities, goods, and services, especially for vulnerable and marginalized people; (2) ensuring access to food, basic shelter, housing, sanitation, and water; (3) providing essential drugs as defined by WHO; (4) ensuring the equitable distribution of health facilities, goods, and services and (5) adopting a national public health strategy and plan of action addressing the concerns of the entire population, devised through a participatory process that pays particular attention to vulnerable and marginalized groups.³⁵ In identifying these aspects, the committee indicates that this interpretation is drawn from the Declaration of Alma-Ata, read in conjunction with the Programme of Action of the International Conference on Population and Development.³⁶

What is significant about the 2000 interpretation is that the committee moves from a fairly substantive notion of core obligations as essential primary health care to a far more procedural and structural approach encompassing equitable distribution, non-discrimination, and a participatory national plan of action. The only health care intervention specified is essential medicines; there is far more explication of the social determinants of health (minimum essential food, basic shelter, housing and sanitation, and water). Other substantive components of primary health care are listed separately but as obligations of "comparable

priority" in relation to reproductive, maternal, and child health care; immunization against major infectious diseases; the prevention, treatment, and control of epidemic and endemic diseases; health education and access to information; and appropriate training for health personnel.³⁷

The challenge of interpreting core obligations

General Comment No. 14 is a watershed moment for the core obligations under the right to health, for it demarcates "essential" aspects of the right to health as a baseline of protection regardless of any given country's shortage of national resources or international assistance. In addition, actions to realize these aspects are located within a legally binding framework that can have considerable normative and political effects. However, it is hard for the definition of minimum core obligations in General Comment No. 14 to practically support these ambitions.

First, beyond essential medicines and underlying determinants (such as food, basic shelter, housing, sanitation, and water), it is not clear which health services fall within the core. Primary health care is not explicitly listed as a core obligation; moreover, much of what we might expect to see in an obligation to provide essential primary health care is explicitly placed outside the core obligations, under obligations of comparable priority. Yet it is unclear what the relationship is between obligations of comparable priority and minimum core obligations. In other words, if obligations of comparable priority are not minimum core obligations, can they be limited by progressive realization or limited resources?

General Comment No. 14 does not sufficiently address the question of the resources necessary to meet core obligations; it merely emphasizes that states cannot justify noncompliance under any circumstances.³⁸ The role of international assistance and cooperation—part of the principle of shared responsibility, which is key to ensuring the universality of human rights and is enshrined in

article 2(1) of the ICESCR—is strongly reasserted as applying to core obligations.³⁹ However, the committee fails to develop a process or specify criteria for assessing when a state has expended its maximum available resources, thus triggering the obligations of international assistance and cooperation specified in paragraph 45. The committee also fails to suggest a burden-sharing mechanism for managing this shared responsibility to realize the core obligations.⁴⁰ This failure to clarify the international assistance obligations of wealthy states while specifying that poorer countries hold strong duties to meet core obligations irrespective of resources leaves the core open to the charge that it places financially unrealistic obligations on poorer countries.

Finally, it is unclear whether minimum core obligations are intended to apply universally or to be tailored to national settings. The committee indicates that core obligations should provide a universally applicable “bottom line” of essential health care, in contrast to a standard that shifts from country to country depending on available resources.⁴¹ However, a one-size-fits-all approach to minimum core health services may be inappropriate given differences in the burden of disease, both among countries and within them. For example, notwithstanding the existence of a WHO list, products designated as essential medicines are often determined nationally, or in some cases sub-nationally.⁴²

Other human rights committees have attempted to fill the substantive gap by extending core obligations to primary health services generally. For example, General Comment No. 15 issued in 2003 by the UN Committee on the Rights of the Child (CRC) holds that states have core obligations to ensure universal coverage of high-quality primary health services, including prevention, health promotion, care and treatment, and essential drugs.⁴³ This interpretation goes far beyond General Comment No. 14’s terser definition, which identifies only essential drugs, and even beyond its earlier suggestion that core obligations extended to essential primary health care. The timing and wording of the CRC’s

General Comment No. 15 suggests an effort to define the right to health in the Convention on the Rights of the Child in relation to ongoing debates over the SDGs and to UHC in particular.

What do core obligations under the right to health offer UHC?

While the interpretation of the Committee on Economic, Social and Cultural Rights regarding core obligations is markedly deficient, it is notably clearer than extant definitions of UHC.⁴⁴ In this light, the remainder of this paper considers what the right to health’s core obligations require of “essential health care services and medicines” with respect to achieving SDG 3.8. This question can be addressed in terms of the interrelated questions of *what* health care services and medicines are included and *who* is covered.

Core obligations and services

UHC’s focus on essential services is clearly consistent with the core obligation to provide essential primary health care. However, General Comment No. 14 provides limited guidance on which elements, beyond essential medicines, must incontrovertibly be included in *essential* primary health care. Certainly if the implication of this inclusion is that WHO determinations of “essential” health interventions provide an authoritative indication of other core obligations, then the General Comment No. 14 definition of core obligations could feasibly be expanded accordingly.⁴⁵ Yet even if such interpretations provide clarity on specific services under cognate areas of health care, such as women’s sexual and reproductive health care, they do not necessarily clarify the broader category of health care services. Thus, interpretative clarity on core obligations stalls at essential medicines, a point that becomes crucial given the UN General Assembly’s inclusion of essential medicines in two locations within SDG 3 (as both a target and a means of implementation, in SDG 3.8 and SDG 3.b, respectively), and which indicates access to essential medicine’s high prioritization by UN member states. Such emphasis will be a major challenge for UHC

achievement in light of the exorbitant cost of some pharmaceuticals. The affordability challenge is highlighted since the indicator for SDG 3.8 proposed by the IAEG-SDG relates to “affordable medicines” and not just “affordable essential medicines.”⁴⁶

However, beyond medicines and some social determinants, the focus of the right to health’s core obligations is far more on processes (e.g., non-discrimination, equitable distributions, and plans of actions) than on outcomes. Indeed, this is the case even with regard to essential medicines, since the determination of what is an essential medicine is made nationally, irrespective of WHO’s determination based on global epidemiological and economic conditions.

Thus, the core obligations do not prescribe a globally applicable and fixed set of health care benefits but rather a framework for action that encompasses non-discrimination (including affordability), equity, participatory decision making, essential medicines, and social determinants of health, which may enhance existing approaches to the prioritization of health care interventions.⁴⁷ It is possible that this framework could do much to advance toward an equitable and rights-based health system. We cannot disagree with this as a principled approach, although it is hard to accept a concept of essential care that includes essential drugs but not emergency obstetric care, immunization, or infectious disease control. This anomaly undermines the broader legitimacy of General Comment No. 14’s interpretation of core obligations.

Essential medicines were perhaps included in the core obligations under General Comment No. 14 to acknowledge the contentious and political nature of access to pharmaceuticals. However, and in turn, the committee might have excluded other measures out of a hesitance to place unreasonable demands on poorer countries by identifying too many substantive core obligations. This is one area where instead of looking to the right to health to augment global health policy, we might do the opposite and consider the specification of SDG 3’s health targets and of tracer interventions in these domains as bolstering what should be considered to fall within a state’s core obligations. Certainly the interplay between global health policy and right-

to-health interpretations is a rich area for future research, especially considering the committee’s declaration that the Declaration of Alma-Ata and the International Conference on Population and Development grounded its decision making around the core obligations.

Core obligations and coverage

While the committee adopted a largely procedural approach to core obligations beyond essential medicines and the social determinants of health, non-discrimination, which is the clearest and most definitive of these obligations, is not simply procedural. With respect to UHC, non-discrimination has very substantive implications for what is covered, as well as who is covered, and has the potential to address structural barriers that impede access to health care. Non-discrimination specifies a focus on the most vulnerable and marginalized sections of society, particularly on denials of health care that fall within prohibited grounds (race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status, sexual orientation, and civil, political, social, or other status). These grounds offer critical protection against discriminatory exclusions in nationally determined models of UHC. In addition, the emphasis on affordability elevates socio-economic status to one of the grounds for discrimination, meaning that UHC which is not affordable to all would violate core obligations under the right to health. These grounds will be very important in implementing UHC and especially in monitoring implementation. They bolster the “equity stratifiers” of sex, age, socio-economic position, and geography that the IAEG-SDG has proposed for disaggregating data collection in order to ensure that UHC does not exclude vulnerable groups.⁴⁸ A pressing question for UHC will be the extent to which non-nationals, particularly those lacking documents, are included, given how some high-income countries have excluded certain classes of migrants from health care in the past.⁴⁹

That non-discrimination has very substantive meaning is apparent in the Committee on the Elimination of Discrimination against Women’s

identification of non-discrimination as a core obligation under the Convention on the Elimination of All Forms of Discrimination against Women, recognizing that states have an “immediate and continuous obligation to condemn discrimination.”⁵⁰ In a 2011 decision regarding a woman who died in childbirth, the committee found Brazil in violation of its core obligation of non-discrimination for failing to assure appropriate maternal health services for all.⁵¹ It held that Brazil’s “continued high rates of maternal mortality ... constitute[d] a systematic failure to prioritize and protect women’s basic human rights” and that the grossly negligent health care given to a poor black woman constituted a form of *de facto* discrimination.⁵² This finding indicates that non-discrimination offers a framework for identifying and addressing systemic discriminations in health care that intensify along axes of gender, race, socio-economic status, sexuality, and disability. The implication of the committee’s decision is that inadequate health care affecting primarily marginalized and poor communities violates core obligations under the right to health. This too is a very important frame for shaping UHC, demonstrating the scope for advocacy and litigation.

The risks of UHC and core obligations

While core obligations can shape UHC, there are risks in focusing too narrowly on them to the exclusion of aspects of the wider SDG agenda. The first is the risk that despite the legal obligation to progressively realize the right to health, core obligations will nonetheless act as a ceiling rather than floor for the right to health, transforming it from health for all to basic health care for the poor only. There is a similar danger of UHC reducing health care downwards, without specifying a floor for essential health care itself.⁵³ The other related threat is that even a well-defined essential health package consistent with core obligations will offer selective rather than comprehensive primary health care, and doing so could reinforce stratified systems of health rights.⁵⁴ This is captured in the argument that health care for the poor often ends up being poor health care, so that the more we “target benefits at the poor only ... the less likely

we are to reduce poverty and inequality.”⁵⁵ Indeed, scholarship suggests that societies pursuing universalistic policies have higher levels of equity than those that rely on selectivity, at least in part because there is an “elective affinity between the preference for universalism and other measures, such as high progressive taxes.”⁵⁶

The risk of UHC becoming targeted rather than comprehensive health care, with inadequate attention to health systems strengthening, is great since states live not in an abstracted world dominated by the SDGs but in the real world, where policies to implement UHC exist alongside ongoing austerity, financial crises, free trade agreements, and pressures to commodify health services, all of which directly threaten policies on access to medicines and sustainable health financing.⁵⁷ Indeed, it is argued that the ambiguity of UHC makes it particularly susceptible to exploitation, particularly within the market-driven global environment.⁵⁸

Conclusion

As we shift into an era of implementing and monitoring both UHC and the SDGs, a priority for civil society and academia must be to guard against restrictions on universality, coverage, and financing that fall short of human rights obligations, as well as against overly abstracted notions of UHC. UHC frames, just like the cube popularized by WHO, literally ask us to think inside a box which excludes key enablers of UHC. These key enablers include social movements and rights-based advocacy and litigation, which are critical for developing UHC in all settings, as well as health systems strengthening, which is required to assure the adequacy of services.⁵⁹ Moreover, such frames do not adequately acknowledge the existence of risks, such as those arising from political and economic pressures to commodify and defund health care. National determinations of UHC in particular are likely to become critical battlegrounds around affordability and inclusion; from a human rights perspective, this is where participatory policies and social movements will become critical factors in rolling out a more equitable version of UHC.⁶⁰

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