



The WHO Council
on the Economics of
Health for All

INSIGHT NO. 5

Advancing the right to health: from exhortation to action

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I. Introduction and overview: the importance of context in understanding and advancing health rights

This paper analyses ways in which the right to health supports health policies, programmes, and infrastructures for the delivery of health goods and services. Whenever possible, the paper also discusses the effect that the right to health has on health outcomes, and the macro-structural constraints that health systems face in their push for the right to health. The result is an analysis that goes far beyond the increasingly common exhortations to enshrine the right to health in legislation or constitutions. Indeed it proposes specific pathways that may produce positive results, namely comprehensive, universal and equitable health systems.

The review shows that adopting the right to health through national constitutions, legislation and/or judicial interpretation can have significant positive impacts on populations' access to health goods, facilities, technologies and services. Treating health as a right provides a compelling moral framework for the promotion and protection of the people's well-being. It is important to acknowledge the link between patterns of health and ill-health on one hand, and social and power relations on the other. The relations, be they gendered, racial, caste, class or other, are in turn shaped by legal and institutional arrangements. Reframing causality to include institutional and legal determinants can equip a right to health to curb de jure and de facto discrimination and foster broader equality in health systems and beyond (Gostin et al 2019; UN CESCR, 2000).

The scope of legal protection varies considerably across countries and depends on the manner in which the right is articulated and on State obligations. It also depends on the institutional arrangements put in place to ensure that in practice the population actually enjoys health-related rights. Besides, while establishing legal entitlements to health is often a precondition, by and large, social values contain a rights framework that is potentially transformative if used for health.

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International law is only a starting point for understanding the right to health. Domestic articulation and institutionalization are equally important. Human rights have become increasingly important in global health governance, and a human rights-based approach can help address health inequalities and promote equity (Gostil et al, 2018). United Nations (UN) frameworks have played a key role in advancing the right to health for many people, while also providing research and support for activism for the right to health. Such frameworks include: the Convention on the Elimination of All Forms of Discrimination against Women; the Convention on the Rights of the Child; Covenants and Protocols of the Convention on the Rights of Persons with Disabilities; five-yearly non-governmental organizations (NGOs) reports general comments and reports of UN rapporteurs, and; communications with the Human Rights Committee. Key frameworks and institutions include the World Health Organization, the International Covenant on Economic, Social and Cultural Rights, and

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the Framework Convention on Tobacco Control. The paper does not focus on the frameworks, but delves into the workings of the right to health in practice, with the State playing an overarching role in defining and shaping markets and institutions that condition, promote or limit the realization of the right to health.

Once socio-economic rights, including the right to health, are incorporated into the constitution it becomes inevitable to translate the broad universal aspirations of international law into local versions that are deeply grounded in socio-historical and political realities. The translation process, which includes interactions with other legal regimes and power asymmetries among the public and private actors concerned, shapes the effectiveness and universality or particularity of health rights (Brinks, Gauri, & Shen, 2015). For example: access to certain sexual and reproductive health services, such as abortion, may fall under criminal law; taxation and/or investment regimes can complicate efforts to address the impacts of private actors on environmental health, or; weak pharmaceutical regulation may turn the right to access medicines into a windfall for drug manufacturers. In short, different articulations of the right, together with institutional and normative contexts, make the right to health a generally robust tool for advancing universal health coverage (UHC), and health justice more broadly.

Of all socio-economic rights, the content of the right to health is particularly indeterminate for empirical and normative reasons. In other words, the population's health needs and the content of benefit packages face constantly evolving empirical conditions (among them demographic and epidemiological shifts, and biomedical innovations). Nevertheless, lack of normative consensus on how to set priorities is a concern. The priorities include: balancing cost-effectiveness; concern for people in the worst circumstances in health terms; the degree of commitment to social equity and to redressing historical discrimination, and; evolving social mores and their impact on health (Daniels 2007; Yamin 2023). For these reasons, the report underscores the imperative of greater public participation in health decision making. International law calls attention to such participation, which is now the subject of extensive public health literature (for instance Ottersen et al, 2014; WHO, 2021). The setting of priorities requires deliberative processes that are anchored to evidence. This is rooted in the same fundamental idea that underpins all human rights: all people are equal moral subjects with dignity, in all their diversity, and are therefore entitled to have a say in decisions that affect their lives.

Social determinants of health play a key role in distributing health and ill-health (Arulkumaran, 2017). Meanwhile, the right to health calls for legal and regulatory measures that extend far beyond the health sector. Precisely for these reasons, the report's focus is not restricted to the health system, which is the central institution responsible for upholding the right to health and often functions as a social determinant itself. Indeed, health systems reflect and communicate normative values that can enhance inclusion or exacerbate patterns of inequality in the larger society (Yamin, 2023). The report also places considerable emphasis on the conditions that a health system must have in order to accommodate a rights-based approach to health. The conditions sometimes go beyond the health sector's remit. They include: fair and adequate financing of health systems, organizing health systems that promote systemic equity, accountability and oversight, and; deliberative processes that are anchored to evidence and meaningful public participation in setting priorities, as well as in macro-structural constraints, such as fiscal austerity. The report's broader focus on variables outside the health sector reflects the need for a whole-of-government approach to advance in the realization of the right to health.

The rest of the report follows the structure described below. Part II provides a narrative analysis to accompany the detailed matrix of legal recognition of the right to health among WHO Member States (the Matrix). The matrix is set out in Annex B. Part III introduces key findings from seven case studies to illustrate the complex relationship between formal legal recognition of the right to health on one hand, and on the other, its enforceability and translation into policies and programmes that make it possible to enjoy the right to health. Annex A contains detailed case studies covering the following seven countries: Albania; Brazil; the People's Republic of China; Costa Rica; India; Kenya, and; Norway. Part IV presents a set of overarching conclusions and 10 actionable recommendations.

In short, the report is a call to action to move beyond a binary analysis that considers whether countries have ratified international treaties or enshrined the right to health in their constitutions. It accentuates the need to address the structural factors that either enable the right to health to bring positive health outcomes for the population, or systematically deny the population the enjoyment of health and related rights; and hold back the creation of robust, resilient universal health systems. This in no way questions the fact that the recognition of health in constitutions and the ratification of international agreements has had significant impacts worldwide. Nevertheless, from documenting the law on paper to understanding the law in action, an imperative emerges: the need for better contextualization to understand how the right to health functions in practice within specific countries, and greater efforts to shift institutional practices that shape financing and global governance for health.

BOX 1: METHODOLOGY

The findings in this paper draw on analyses of legal frameworks relating to health in WHO Member States which are set out in the Matrix in Annex B, and on seven additional case studies selected for the purpose of deepening understanding of the workings of the legal frameworks (see Annex A).

➤ The purpose of the data collection for the Matrix was primarily to establish which WHO Members include the right to health in their constitutions. The collection includes legal documents of constitutional character from reliable international databases (from [Constitute.org](https://www.constitute.org/), the Venice Commission and the International Labour Organization, among others.) in English, and from specific domestic directories of legislation available online. In cases where no English source or official translation was available, the report opted for the version in the original language.

➤ The next step was to subject WHO Members that do not have an explicit constitutional right to health to a second level of analysis to determine whether they had either: (i) a statutory right to health; or (ii) a judicially constructed constitutional right to health. This for instance means converting 'directive principles' into fundamental enforceable rights, and; finding aspects of the right to health in the right to life. The secondary analysis relied on research using the relevant national legal databases and academic literature on judicial enforcement.

➤ For each WHO Member State, the Matrix contains the legal basis for the right to health, the category of recognition (constitutional, legislated, judicial, or a combination of these) and, when appropriate, the year of the last revision or amendment of the legal source and an extract of the constitutional text containing the right to health reference. The entire report contains examples of specific formulations, based on the Matrix.

➤ Case studies were developed to supplement as well as cross check the analysis that was based on the Matrix. In order to fully explain the workings of the right to health and its constraints in specific contexts, seven cases were selected that add geographical variety and show differences with respect to: (i) the system of government (unitary versus federal state); (ii) source of the recognition of the right to health (constitutional right, judicial recognition, or legislation); (iii) framing of the right (the right to health versus the right to health insurance); (iv) public expenditure on health, and health coverage (universal health care coverage index, and out-of-pocket expenses); and (v) the role of international institutions in influencing State behaviour. The report provides certain examples (in parentheses) that refer to information described in greater detail in the case studies themselves, in Annex A.

II. Legal recognition of the right to health among WHO Member States

Under international law, the affirmative dimension of a right to health is a right to access health facilities, goods and services, including those that relate to underlying public health preconditions. In turn it imposes obligations on States to respect the conditions necessary for access, to protect them from third parties, and to fulfil the right by adopting all appropriate legislative and other measures to progressively realize universal access in practice (ICESCR, 1966; CESCR 2000, CESCR 2017). No such thing as the right to be healthy exists either under international or national law, nor can a right to health call for the equalization of all health outcomes. Firstly, this would make the enforceability of the right to health impracticable and legally indeterminate. Secondly, and equally importantly, the goal of advancing health rights is not confined to improving end-states. It also calls for advancing a life of dignity which requires multiple rights – and institutional arrangements that allow people to have a say in their lives and well-being. Progressive realization of the right to health is therefore consistent with, but not equivalent to progressive achievement of UHC (Ooms et al 2014). It might help to conceptualize the right to health as a tool or building block—one among many rights—to enable diverse people to live a life of dignity, by freeing them from coercion and dependence, and to carry out their life plans. Therefore, the right to health requires the regulation of private actors within and beyond the health system, as well as freedoms from coercion (such as involuntary treatment), and affirmative entitlements.

The right to health features in approximately three-quarters of the constitutions of the 194 WHO Member States (at least 140). Each constitutional right to health is unique and reflects the specific legal systems and political decisions of the State. The relationship between international law and national law is complex and varies among countries, even among those where constitutions incorporate human rights treaties directly into their texts. Therefore, comparing constitutional rights to health entails much more than tracking textual references to obligations involving health. It is imperative to conceptualize legal analysis through a careful examination of language, scope, enforceability and possible interpretations that have been or may be made within a country. It is equally important to note that judicial decisions and/or national legislation can serve to recognize domestic right to health obligations recognized in a WHO Member State.

The Matrix of legal recognition among Member States (see Annex B) spells out the common variations in the right to health as defined by constitutions across WHO Member States. Constitutions are the highest domestic legal authority—most often in a written document, but unwritten or “invisible” constitutions do exist, for example in Israel or the United Kingdom of Great Britain and Northern Ireland. Constitutions enumerate basic individual and collective rights and lay down the shared functions, powers and responsibilities across all levels of the State (Tushnet 2012). A number of countries use a mechanism called a constitutional bloc to directly incorporate international human rights law into the constitutional text when they ratify treaties; others incorporate international laws (automatically upon ratification or through implementing legislation) into domestic law which gives them the same authority as national legislation.

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In addition to indicating whether the right to health is present in different constitutions, the paper describes basic attributes of how a right to health is enshrined in a constitution, namely: a) a language and scope of the constitutional text, b) other possible means of recognizing the right to health through courts and legislation, and c) legal context that influences the manner in which rights are interpreted and enforced.

This methodology avoids the unhelpful reductivism in comparing constitutions as if all States were bound to the same scope of the right to health. It is important to take into account variations in the legal basis for and the content of State obligations in assessments of the ways in which the right to health can help advance population health and strengthen health systems in each State.

A. Language and framing of constitutional rights

When States explicitly include the right to health in their constitutions, they do so on their own terms, through domestic political deliberation. The resulting language and provisions are distinguishable from the formulation of the right to health in international law. The constitutional process need not mirror the reference in the preamble to the WHO Constitution (WHO 1946) nor the core formulation under international law, which refers to the „right to the highest attainable standard of physical and mental health“ (ICESCR 1966). International law provides parameters for assessment, just as it does with respect to civil rights such as the due process of law or the freedom of speech. However, just as what constitutes defamation or the evidence and procedures involved in a due process of law vary considerably across democratic countries, so too do protections for the right to health.

Different framings yield varying results in practice. Moreover, it is misleading to assess States based on snapshots in time because constitutions are frequently amended, legislation and judicial interpretations of health and indirectly related rights evolve—and health systems continually undergo reform. All of these factors determine how a right to health operates in practice (Kavanagh 2016; Backman et al. 2008; Heymann et al. 2013; Kinney and Clark 2004).

The scope of this report makes it necessary to limit the catalogue of constitutional provisions to those that directly concern access to health care or public health services as of 01 December 2022 (see methodology overview in **Box 1**). This approach indicates the crucial constitutional provisions for health without necessarily giving the full picture of how a constitution as a whole protects or recognizes health, or how legislators and institutions understand health as a matter of the basic social contract. Some constitutions have specific rights for certain health-related obligations, such as the right to a healthy environment or labour protections. Parts of the constitutional text may refer to rights to food, water, education and housing, which are all elements of social determinants of health. Additionally, rights to freedom of information and movement, as well as standards of non-discrimination, are all essential to the effective enjoyment of health and related rights.

Non-discrimination and equality guarantees are an example. A guarantee of formal equal protection, which requires treating similarly situated people the same, can eliminate de jure discrimination based on race or sex. That is very important in health for curbing legal discrimination; it also implies the need to make treatments offered in health systems universal for all people suffering from the same condition. Nonetheless, formal equality can mask underlying power asymmetries. Substantive equality, by contrast, involves equalizing effective enjoyment in practice when people are not similarly situated.

For instance, men and women require different reproductive health services and in countries with substantive equality, gendered readings of the right to health have played essential roles in expanding services in health systems. Likewise, substantive equality guarantees make it possible to adopt positive measures to promote the health of disadvantaged and marginalized groups. For example, equality norms largely determine whether providing sign language interpretation for deaf patients is considered as an effort to equalize the effective enjoyment of the right, or an additional service being requested. This distinction is extraordinarily important in health, as health systems must invariably meet the health needs of very differently situated groups.

With respect to the right to health care and public health protections specifically, constitutions vary substantially. Some constitutions may adopt an expansive stance over health and health care, and recognize numerous health obligations in more than one article. Broader textual references to the right to health may prescribe the conditions or specific policies that the State must achieve for health, such as primary healthcare or vaccination. In some constitutional texts, multiple obligations in different parts of the document are read together to generate an enforceable right to health. These might include, a right to an adequate standard of living; a right to a healthy environment, and; consumer protections. Other texts are more succinct, with a right to health consisting of a single line stating that all individuals (usually understood as citizens or legal residents) have a right to health, without detailing the related obligation expected from the State.

To illustrate these content variations, the report focuses on a few distinguishing elements: (i) explicit references to public health; (ii) rights set out as programmatic aspirations or directive principles; (iii) an explicit reference to other laws or regulation to enact the right to health; (iv) explicit reference to free healthcare; (v) explicit obligation to protect the health of people; (vi) focus on population-level public health protections and; (vii) mechanisms of resources and financing.

Public health: content and themes described within State policies and responsibilities that concern health at the population level not solely related to treatments or medical care, involving the prevention of diseases and epidemiological surveillance, through measures of health promotion or reduction of health risks.

Programmatic goals: A right to health may be established under a set of social objectives or directive principles as part of a constitutional vision of State development and organization. Programmatic goals, sometimes found in constitution preambles, may be interpreted as collective aspirations as opposed to fundamental rights with full individual enforcement and protections (in Belarus and Bhutan). This language may be interpreted as just an

institutional commitment of a political nature, which may orient State governance as long-term programmes, without immediate enforcement. In other cases, as discussed below, constitutional courts have adopted anti-formalist tools of interpretation to declare the distinction between fundamental rights and directive principles. As such, they have judicially constructed the right to health as an enforceable right (examples include Colombia and Uganda—in relation to maternal health care).

Provided by law: a conditionality or clause that subjects the realization of rights or policies to further legislation or regulation.

Free health care services: A minority of constitutional texts explicitly mention the provision of free health care; out-of-pocket payments are permissible even when there is an explicit right to healthcare.¹ Constitutions of WHO Member States contain at least 44 explicit references to free healthcare. Some variations of the right to health will only stipulate free health care for basic services or for people in extreme economic need (for instance in Tajikistan).

In other cases, the constitutional text may not necessarily imply public delivery of health care services, because the right is articulated as the right to “health protection,” which may refer only to some forms of public health protection at a collective level (as opposed to individual treatments).

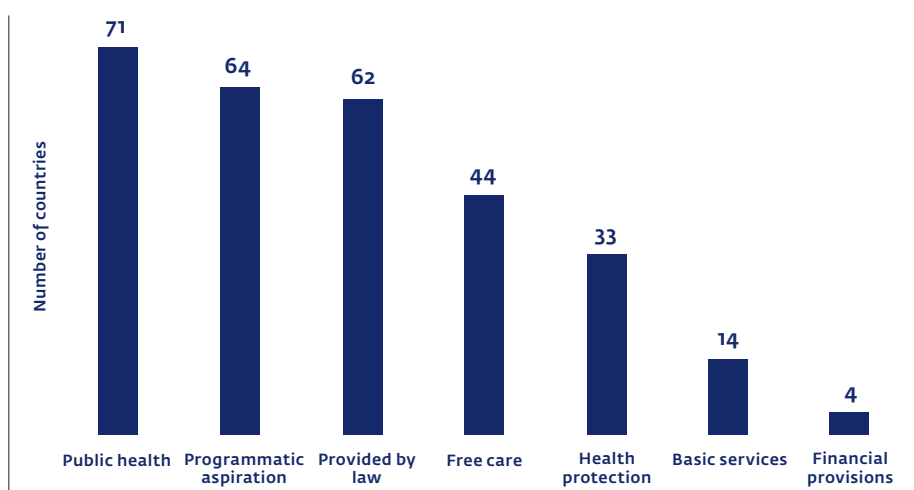
Health protection: explicit reference to the State’s obligation to protect the health of people residing within a country.

Basic health care services: A constitutional right to health may be expressed more restrictively as a right to basic or essential health care services. Various terms can be employed to denote a minimum or essential level of health care, such as “basic health care” (for instance in Armenia) or “minimum health insurance” (for example in the Republic of Moldova), or even just emergency health services. The enshrinement of a right to basic obligations at the national level rarely stipulates the contours of the services, which tend to be in legislation or regulations. Note that a country’s provision of “basic services” need not map neatly onto “basic obligations” set out in general comments and recommendations from Treaty-Monitoring Bodies.

Financial provisions within national constitutions: Constitutions rarely explicitly set out the sources of financing or the rules of health care expenditure. Exceptions to this rule include Brazil, Colombia and Ecuador which all provide detailed regulation of health care financing, and Egypt, which earmarked 3% of its gross domestic product (GDP) for health. Constitutions may establish specific taxation to finance health or determine federal revenue transfer for health in local governments, which may also have to ensure minimum spending in the sector. In other instances, given a lack of specificity, the State may choose among varied financing options or some combination thereof, including general taxation, specific consumption or other taxes, and private as well as social insurance.

Figure 1 provides a visualization of how the right to health is understood differently in different contexts, and makes reference to the concepts explained above. For further details on the definition and categorization of variables, see Annex B.

FIGURE 1: Concepts referred to in relation to the constitutional recognition of the right to health, including in 140 WHO Member States.



B.

Alternative routes: legislation and judicial construction of health rights

The recognition of a right to health can be achieved through both judicial construction and legislation. However, legislation and judicial construction can also interpret other rights, such as the right to life, to incorporate elements of the right to health, including access to care (as is the case in India and Costa Rica).

Compared to other forms of recognition, constitutional rights have a unique advantage in that they occupy a higher status in law and are more challenging to repeal with changes in political priorities than regular legislation (Gardbaum 2006). Constitutions stipulate the social contracts between subjects and the State, set narratives regarding social inclusion and equality, establish certain institutional arrangements (legislative, judicial, executive and sometimes others), and in general hold a wider scope of influence over government policies compared to ordinary legislation. In theory, any legislation or administrative act can be challenged if it infringes upon the constitutional right to health. Judicial scrutiny of constitutional rights tends to be less deferential than that of administrative acts or ordinary legislation, as comparative case law demonstrates. Moreover, in many jurisdictions constitutional rights obligations are applied horizontally to govern private relations, including business transactions (Gardbaum 2003). In health sectors where private providers and insurers play significant roles, this horizontal application of constitutional rights has turned out to be critically important.

The judicial construction of health-related rights occurs through iterative interpretation of the constitutional text, a process informed to differing degrees by international human rights law. Courts may issue judgments that effectively establish a right to health within a constitution (examples include Costa Rica and India). While such judicial interpretations may appear to have the same weight as an explicit constitutional article on the right to health, they can be more narrowly circumscribed to certain types of care (for instance maternal health in Uganda).

The decisions typically derive the right to health from other constitutional rights, most commonly the right to life and the principle of dignity (Carlson et al. 2020; Keener and Vasquez 2008). The right to life with dignity, in this view, comprises adequate standards of living, including access to healthcare. The use of the right to life as a basis for the right to health can prove limited and problematic, as in the case of access to abortion or in vitro fertilization in Costa Rica. However, this is not always the case, as the counter example of India demonstrates.

C.

Socio-legal context: enforceability and the full breadth of rights in a constitution

While the textual articulation plays an important role in understanding the effects of a right to health within a constitution, the broader legal context in which a right operates is also vital for State compliance with constitutional obligations. One cannot decode the meaning of the right to health by examining the text in the abstract; it must be considered alongside the general rules of enforcement of individual and collective rights, particularly non-discrimination, the protection of autonomy and access to information. These inter-linked obligations may depend on other special constitutional rules that extend consideration far beyond a single provision regarding the implementation of a right to health (for example, standing, protection writ mechanisms, the permissibility of *amicus curiae* and expert testimony) or related legislation, and/or judicial interpretations of other rights.

Examples of these basic complementary rights and principles include gender equality and special protections for marginalized groups such as indigenous peoples, children, and persons with disabilities. This wider constitutional framework is also central to a human rights-based approach to health policies (Coggon 2020; Kittelsen, Fukuda-Parr, and Storeng 2019). The right to health has been key in supporting inclusive systems, in particular where certain groups have been excluded from State policies but leveraged their position by mobilizing constitutional rights, such as with advocacy for maternal services or HIV treatments (Dunn, Lesyna, and Zaret 2017; Heywood 2009).

However, the transformative potential of enshrining the right to health in constitutions remains limited by: (i) resistance to giving “teeth” to socio-economic rights, including health, because of their enduring image as political issues better suited to legislative than judicial control; and (ii) the lack of institutional infrastructures necessary to realize the effective enjoyment of health-related rights in practice; (iii) the economic order present in the State as well as the influence of transnational factors, such as intellectual property, international taxation rules, debt and austerity. Introducing a right to health in a constitution will not by itself resolve such structural limitations.

Additionally, human rights fact-finding must evolve to meet the changing needs of contemporary human rights challenges, and there is a need for new forms of fact finding to ensure effective protection and promotion of human rights (Alston and Nuckley, 2016). Specifically, the traditional fact-finding model relies on witness testimony and document analysis, but is inadequate for modern contexts. It is vital to incorporate technology, social media and other digital sources of information, which should be as focused on prevention as possible, instead of being reactive.

D. Access to justice and remedies

Rights require effective remedies in the event of violation; in turn, that requires not just the existence of the norm but structural innovations to allow people to get access to courts, and for courts to issue an enforceable remedy with respect to the violation. The enforceability of health-related rights depends not just on the constitutional text itself but on, among other factors, different degrees of awareness about rights violations (in other words legal consciousness), and the need for and availability of counsel; rules regarding standing, and financial costs of filing a claim in a jurisdiction (Gloppen 2008; 2015). Further, a right to health may be justiciable and, even after litigation, remedies (ranging from individual entitlements to policy changes) may not guarantee State compliance (Hogerzeil et al. 2006; Ferraz 2020; Colleen Flood and Aeyal Gross 2014; Landau 2019; Roach 2021; 2022). For example, while the Costa Rican legal system guarantees immediate compliance in claims involving constitutional protection (amparos), Peru, which also has such protection writs, lacks mechanisms to oversee compliance.

Claims have come to light about the anti-democratic effects of courts' involvement in health policies, and arguments abound about the distortive effects of judicial concessions of individual health entitlements. While an in-depth discussion of such arguments is beyond the scope of this paper, the paper reaffirms other work by leading scholars that have established that the right to health is not incompatible with evidence-based priority-setting (Rumbold et al 2017). Further, the dichotomous portrayals of judicialization, as good versus bad, overlook the dynamic and evolving nature of how courts approach adjudication and remedies. In certain countries with very high levels of litigation, judicial involvement is more attributable to exasperation with the indifference of the political organs of government than it is to judicial activism; where the government inspires low levels of trust and priority-setting is neither systematic nor transparent, and courts are readily accessible, people tend to seek relief through judicial claims.

It is true that structural remedies that affect broad policies and rules (such as intellectual property; rules regarding issuance or rescission of insurance, and; curbing discrimination within systems) tend to be more pro-poor than individual claims. However, the overall impact of all judgments—structural, collective and individual—depends on the way in which the executive and legislative branches respond to judicial rulings (Langford, Rodríguez-Garavito, and Rossi 2017). In a number of countries that have had significant health rights litigation, courts are actively experimenting with ways to enhance State compliance. These include public hearings, scientific expert panels and dialogical structural remedies that set out parameters for State compliance. They seek to catalyse action by political branches as opposed to

one-off black-letter rulings. Judicial rulings can also play broad educative functions, which reframe health care from being a good or service to a fundamental asset of citizenship and part of the social contract. The reframing function has played an extraordinarily important role in shifting public discourses on health from a focus on lapses in quality of care to fundamental matters of equal dignity (Yamin, 2023).

In short, an analysis of the data demonstrates the existence of varied framings and contexts of the constitutional right to health, and they in turn open distinct pathways for access to health care. Enshrining the right to health can affect not just the adjudication of specific cases; it also orients social norms and structures the design and governance of health systems (as in the case of Brazil). The constitutionalization and/or judicial construction of the right to health can affect political cultures and shift people's expectations regarding the State's obligations, which creates pressure for governmental responses (which occurred in Colombia). However, the link between constitutional codification and health outcomes or spending is far from linear and is always shaped by other institutional variables.

» The constitutionalization and/or judicial construction of the right to health can affect political cultures and shift people's expectations regarding the State's obligations, which creates pressure for governmental responses «

Research on the positive effects of constitutionalizing health rights is still developing appropriate methods to determine how rights may act differently in transitional or non-democratic contexts. Nonetheless, in all cases, this review suggests a need for more comparative research based on deep local knowledge to determine how the law works. Claims about universal expertise in decoding positive international obligations too often produce blinkered analyses that hardly help in understanding how health rights effect change in particular contexts, and may obscure political arguments on the colonality of international law itself.

III. Top-line findings from case studies

An analysis of specific country contexts in the detailed case studies set out in Annex A reveals the path dependence of advancing health rights, as well as some inferences regarding health financing and governance across contexts. Criteria for the selection of the seven countries included: preparation of the seven case studies, including relevant constitutional and other legal provisions, together with important judicial constructions; health system organization and financing and; socio-historical and transnational factors, such as debt burdens and colonialism. As none of the countries were categorized as extremely low-income, Partners In Health provided additional information from Liberia and Sierra Leone (see Box 2).

The case of Albania (right to insurance) illustrates the risk of framing the right to health as an entitlement to health insurance without regard for the economic conditions in the country, including the labour force.

There are considerable limitations inherent in recognizing legal rights within a context of neoliberal reforms driven by international financial institutions (IFIs) that have fostered lower public expenditure, the promotion of private participation (and public private partnerships) in the provision of health services (such as laboratories, drug supply and diagnosis) and the weakening labour rights that have thrust more people into informality.

The case of Brazil (constitutional right) demonstrates the importance of embedding the right to health in broader structural reforms aimed at addressing social inequalities in a democratic State of law, as well as the need for the State to actively regulate private and public actors in the health sector. The right to health is a key part of the social contract, which also established the unified health system and fostered changes to health governance with broad social participation at the local levels. Moreover, Brazil is one of only a handful of countries where the constitution makes provisions for funding the health system, and the only country in the world where a universal system applies to people regardless of citizenship or immigration status. Nonetheless, weak oversight and regulation divert funding to private providers, and away from the public system.

The case of Costa Rica (judicial construction) presents the importance of a universal social security system that emphasizes primary care to institutionalize a right to health, while also signalling the challenges of aging populations and more chronic health needs that call for expensive care. Costa Rica also highlights the importance of transparent and participatory mechanisms to make and implement health decisions. Even where there is comprehensive health coverage, some treatments are inevitably excluded. People have a right to have health priorities justified to them, and failure to do so in Costa Rica undermines public trust and drives individual judicialization.

The People's Republic of China (health system reform towards universal health coverage and legislation recognizing the right to health) shows how countries that lack a constitutional right to health can undertake significant reforms to improve health outcomes but still may exclude certain populations and issues.

The People's Republic of China has recently adopted a rights discourse in some of its health legislation and policies, including establishing that citizens shall, in accordance with applicable laws, have the right to receive basic medical and health care services. Despite prioritizing areas with significant minority populations, autocratic, top-down processes have led to the over-use of in-patient care and failed to mitigate discrimination against, and the marginalization of certain populations. Additionally, they have not mitigated low levels of trust.

The Indian case (judicial construction of the right to health based on the right to life) illustrates the important symbolic as well as extra-territorial impacts of a judicially constructed right to health care, while also revealing the limitations of the Indian Government's judicial power to catalyze broader policy changes, including financing, that would transform access in practice. Judicial interpretations of intellectual property rights have played an enormously important role in enabling India to become 'the world's pharmacy'. The judiciary has also issued expansive orders seeking to eliminate bureaucratic barriers that restrict access to care for indigent and marginalized populations (including members of scheduled castes). Nonetheless, high dependence on public-private partnerships and the private delivery of care significantly undermines access as well as equity within India, despite recent efforts to extend primary health care.

The case of Kenya (constitutional right) reveals that low- and low-middle income countries can make efforts toward the progressive realization of the right to health, and to manage the constraints they face in financing a robust health care system. While Kenya's 2010 constitution enshrined a robust right to health, in practice enjoyment of that right remains limited as a result of financing through social insurance, and of decentralization that overlooked democratization and social participation at the sub-national (county) levels. Additionally, the State has weak capacity to implement significant judicial decisions on health rights. Debt payments and austerity imposed as a result of loan conditions undermine the fiscal capacity needed to advance health rights.

The Norwegian case (legislation recognising access to health care and patients' rights) illustrates the important role priority-setting plays in creating a fair and inclusive health system even in a context of tremendous resources, because no country can meet all health needs, including those with the capacity to do so. Norway's health system is consistently described as comprehensive and impressive in terms of outcomes (OECD 2014).

The cases of Brazil and Norway reflect the importance of such democratic principles in creating mechanisms for public participation in health decisions, which in turn enhances the legitimacy of the health systems as core social institutions (Freedman et al, 2005; Yamin, 2023). In addition to Brazil and Norway, the case of Costa Rica also illustrates that when health rights are imbedded in the political culture as fundamental social values of equality and social solidarity, it provides a clear and compelling case for investing in universal access to health goods, technologies services, and facilities, and for creating regulatory frameworks that advance UHC.

For their part, the Albanian and Kenyan case studies illustrate the constraints that many national governments face in their capacities to sustain resilient universal health systems and progressively realize the right to health. At fault are political determinants of health, which include austerity, debt and intellectual property regimes, that abound in transnational space. For example, austerity affects progress in achieving the right to health in multiple ways, including: (a) in the health system, for example through wage cuts or layoffs of health personnel; increases in co-payments and out-of-pocket expenses even for critical services such as ante-natal and delivery care; reduced benefit packages or changes to eligibility criteria; disrupted access to insurance, and; cuts to certain areas of health; (b) indirectly, through cuts in the education sector; reductions in support to food-assistance and security programmes, and; through reduced funding of temporary housing or shelters and housing subsidies that poor women and other gestating persons² depend upon, and; (c) generally, through reduced unemployment support and the tightening of targeted social programmes, disproportionately used by women and children.

Very low-income countries fare even worse, with minimal fiscal capacity—despite increases in health expenditure as a percentage of GDP—translating into higher out-of-pocket payments and reduced care seeking (see Box 2 below with data from Liberia and Sierra Leone).

BOX 2:**OUT-OF-POCKET EXPENDITURES INCREASED DURING THE CORONAVIRUS PANDEMIC (COVID-19) AND POSE MAJOR BARRIERS TO**

While the COVID-19 pandemic led to an increase in health expenditure by donors and governments, out-of-pocket expenditure also increased in many countries. Inadequate investment in health and lack of financial protection which often results from under-financed health systems can force patients to forgo necessary health care. In Sierra Leone, health expenditure as a percentage of GDP increased from 8% in 2015 to 15.5% in 2020 while out-of-pocket expenditure surged from 36.7% in 2015 to 55.7% in 2020. In Liberia, health expenditure as a percentage of GDP rose from 11.4% in 2015 to 16.7% in 2020, yet out-of-pocket expenditure also increased over the same time period.

Preliminary findings from a study conducted in 2020 by Partners In Health Liberia and Partners In Health Sierra Leone show that on average, 75% of study participants in one district in Sierra Leone cited cost of transportation or cost of a doctor's appointment as the primary reason they do not seek care. Overall, 25% of the households who participated in the study experience catastrophic health expenditure (CHE) at the 10% threshold. In one county in Liberia, 28% of the participants cited transport and the cost of a visit as major barriers to accessing care, and 24% of the households experience CHE at the 10% threshold. In both countries, where much of the population lives below the poverty line, the cost of a visit can range from US\$ 0.42 to US\$ 135.

Sources: Global Health Expenditure Database (who.int) Partners In Health

International financial institutions and other multilateral organizations—such as the Organisation for Economic Cooperation and Development (OECD)—have often promoted health reforms as part of structural State reforms, and recommended reducing State participation in service delivery, and containing costs. While the private delivery of services does not per se violate the right to health, achieving the right to health requires the State to play more than a gap-filler-role; it calls for robust regulation and market shaping to ensure equity and accountability.

Across the case studies, in high- and low-income countries alike, it is evident that financing health systems presents challenges as populations age, with chronic and non-communicable diseases constituting a greater share of the burden of disease and access to health technologies and new medications becoming increasingly expensive. In many cases, States could show commitment to health-related rights by allocating more to health (and other social rights related to health, such as education). However, low and low-middle income countries cannot do this alone, as they often face steep penalties in credit ratings, access to further monies and litigation from private creditors.

» It is evident that financing health systems presents challenges as populations age, with chronic and non-communicable diseases constituting a greater share of the burden of disease and access to health technologies and new medications becoming increasingly expensive. «

IV. Conclusions and recommendations

An overarching conclusion of this report is that it is insufficient, and potentially misleading, to base conclusions about progress on mentions of the right to health in constitutions. A variety of factors determine the meaning of the right and how people can access goods, facilities and services in practice. The factors include: (1) the framing and articulation of the right (such as insurance versus free care); (2) the other rights and norms in the constitutional text (such as equality guarantees), and; (3) the organization of power in the constitution, which may support or frustrate the capacity of courts to enforce rights and issue meaningful remedies as well as determine ways in which to carry out financing among levels of government.

Incorporating the right to health in constitutions does not automatically translate into material outcomes, while reframing the role of health systems provides some of the most important pathways for change. It is not uncommon to conceptualize health care and health systems as charity from religious institutions, social security for specific workers, and as markets for goods and services. In the 21st century, with the ever-accelerating pace of biomedical and biotechnological advancement, health systems are often treated as mechanistic apparatuses, governed by technocratic logics and expertise alone.

A right to health reframes entitlements to care as an asset of citizenship and part of the social contract. Some of the most significant advances in countries that have adopted a right to health in their constitutions involved the reframing of issues previously considered as technical administrative matters in the health system (for instance the inclusion of HIV medications in formulary) or lapses in quality of care (such as lack of emergency obstetric care) in terms of fundamental rights and dignity.

Similarly, **other major advances have involved the reframing of matters previously excluded from the political sphere because they were considered private, moral issues in terms of rights in a democratic social contract.** For example, the right to health has underpinned the transition in multiple Latin American countries from considering abortion as a private moral issue to seeing it as an issue that concerns actual access to life-saving care required only by women and other gestating persons (for example in Colombia and Mexico).

Both kinds of reframing work, not just to advance material access to specific health goods and services; they shift political culture and have important ideational and discursive effects on both individuals and the institutions that are responsible for meeting population health claims. The reframing of health systems as core social institutions can enable health providers to see themselves as guarantors of health rights (for example the evidence about shifting provider attitudes regarding abortion in Argentina). Such important transformations of social values rarely follow linear pathways. Rather, they are influenced by contextual (for example changes in political administration, and in labour regimes in health systems) exogenous factors and events (such as the 2008 global financial crisis and austerity that followed, and; pandemic shifts), and evolve over time.

The research underlying this analysis emphasizes that in order to realize the transformative potential of the right to health, it is vital to reframe and reclaim issues that are increasingly the reserve of 'private markets' and which concern fundamental dignity, political equality and changing institutional governance in commensurate ways. As the Council has stressed in other respects, achieving the right to health in practice requires significant market-shaping initiatives on the part of governments with respect to health systems directly, and with respect to social determinants of health.

Just as the law creates the borders between the public sphere of rights and the private sphere of personal morality, so too does it create the boundaries between the public administrative sphere and private markets. It is overly narrow to view the role of the law as affecting individual behaviours and the built environment (Gostin et al, 2019). A variety of regulatory vehicles, including anti-trust laws, tax laws (income/wealth/financial transactions as well as consumption), financial regulations, administrative law and intellectual property shape health care and all markets, as well as concentrations of economic and political power. The false narrative of scarcity that permeates discussions on achieving UHC stems from acceptance of the status quo; advancing the right to health and universal dignity provides a compelling reason to reject this narrative.

There is a need to have more robust direct regulation of private and public actors, complemented by changes in legislation that create appropriate incentives.

(They include taxation that structures incentives for investments in health systems and provides resources for redistribution toward health; tailored agricultural subsidies, public funding, and contingencies with respect to scientific research.) **Additionally, global rules and incentives determined beyond national borders must change.**

(Examples include incentives for sharing technology, issuing compulsory licences, and creating platforms for pooling research and development and access to medical countermeasures at the regional and global levels.) Just as participation in national policy making and priority setting is key to advancing the right to health, so too is democratizing the governance of global funds to include low- and low-middle income countries together with civil society.

The effectiveness of the right to health in promoting better and more equitable population outcomes highly depends on transnational forces that affect both financing and governance of health systems, as well as social determinants of health. Since the late 1970s and early 1980s a narrative depicting neoliberal globalization has taken hold in health financing across the globe, promoting fiscal consolidation, privatization and deregulation (including of labour protections for health workers and others), and targeting a small set of basic services to the poor. Zealous pursuit of trade liberalization through agreements that impose tariff reductions and rigid intellectual property restrictions also very significantly

» It is vital to unlock the transformative potential inherent in the right to health in order to promote meaningful UHC, and health justice more broadly. «

affects the availability of funds for health in low- and low-middle income countries, and the countries' sovereign capacities to govern their own health systems. In the wake of the pandemic, the International Monetary Fund is projecting added layers of debt and in turn austerity, which will further reduce health spending and States' capacity to provide infrastructures to deliver UHC. Enhancing national capacity for market-shaping in health calls not just for vastly increased financial assistance, and democratized governance of global health aid. It also calls for: a halt on the imposition of further fiscal consolidation; the restructuring and cancelling debt, and; the creation of much stronger incentives/rules for private creditors to participate in restructurings on fair terms.

In short, calls for constitutionalizing or legislating the right to health in and of themselves will not change the enjoyment of the right to health in practice. It is vital to unlock the transformative potential inherent in the right to health in order to promote meaningful UHC, and health justice more broadly. For this to happen, it is necessary to change national laws that structure markets, along with international agreements that define sovereign governments' capacities to shape and regulate markets that concern health care access and social determinants.

Recommendations

1.

There is a need to encourage States to revise fiscal policies to permit adequate financing, sufficient pooling and purchasing, as well to strengthen regulatory oversight and adopt creative financial mechanisms and policies to promote access (from public-private partnerships to procurement rules) that shapes health care markets while preventing violations due to outright market failures. States must assume or reclaim their responsibility for stewarding universal health systems in high-income and low-income contexts alike. Only then will the right to health fulfil its transformative promise of underpinning: people's claims to health goods and services as assets of social citizenship, and; the responses of governments.

2.

The World Health Organization should work with other UN agencies, multilateral institutions and civil society organizations, in addition to normative frameworks, to shift public narratives around the need for appropriate infrastructure, resources and State capacity to advance a progressive realization of the right health. The evident need for greater resource mobilization for health systems in high- and low-income countries alike calls for a shift in narratives as much as a change in specific policies. It emphasizes again and again the array of possibilities for legal reform at the national and international levels.

3.

To understand the achievements that the right to health is making and the limitations it faces, UN treaty-monitoring bodies, and the Human Rights Council – through the Universal Periodic Review – should intensify and regularly focus their reviews on infrastructural needs. They should also highlight structural barriers to the effective enjoyment of the right to health in practice, rather than concentrating on normative frameworks abstracted from context.

4.

Donor States should commit to providing stable, long-term investments in public health systems. At the same time donor States and IFIs should commit to helping countries place a higher priority on investment in the health sector than on debt payments, and to providing private creditors with incentives for collective agreement on loan restructuring.

Many countries cannot strengthen their stewardship capacities alone; donor countries have extra-territorial obligations to provide international assistance and cooperation and protect the right to health from infringements by entities over which they exercise effective control, both directly and through multilateral organizations.

5.

The World Health Organization should undertake to compile evidence of specific local market distortions and barriers to the implementation of the right to health, along with guidance on good practices in innovative legal approaches to market shaping and regulation at the national level. There is no "regulatory framework" minimum that a given country must have before promoting private participation in the health sector because many of the issues raised relate to institutional design. However, the right to health calls for States to ensure robust oversight, and the incentivization and regulation of private actors who engage in activities that affect population health, provide health goods and services, or finance health goods and services.

6.

Health reforms sponsored by IFIs should not promote social health insurance as a blueprint policy across the globe unless structural conditions are in place that permit sustainable financing. Such conditions include but are not limited to long-term investments and a labour market that is not skewed toward the informal sector. Without such conditions, it is important to be weary of the risk of reducing a right to health to mere access to social insurance. As evidence across the cases collected here and elsewhere suggests, this will promote inequities and create fragmentation.

7.

Decentralization of health systems should involve robust mechanisms for social participation and social accountability and centre around shared financing obligations. In the absence of such conditions, decentralization can exacerbate inequities and fragment resources. Moreover, decentralization often involves a larger number of sources of funding and how it is delivered, and requires heightened regulatory oversight of supply chains, procurement, distinct local health care markets, and the like.

8.

It is vital to incorporate evidence-informed deliberative processes into all health systems, with external expertise provided by WHO and other groups, as needed. While UHC is aligned with the right to health, the right to health requires more than technocratic efforts to achieve universal health coverage. All people have the right to have public policies justified to them, and therein lies a need to create mechanisms for meaningful public participation in health decision-making.

9.

Based on the right to health, national governments should strengthen their legal capacities to maximize all flexibilities under TRIPS and bilateral agreements, and insist on strictly limited indemnity clauses and transparency in all agreements with transnational pharmaceutical companies. Likewise, donor States must refrain from penalizing or bullying States that exercise their rights under trade agreements regarding, for example compulsory licensing and parallel imports. Additionally, donor States with substantial pharmaceutical industries should use all available legislative and regulatory tools to provide incentives for the transfer of technology and know-how. Establishing an appropriate mechanism for the sharing of the benefits of scientific progress should be a binding article in a future pandemic accord, along with revisions of the 2005 International Health Regulations.

10.

The World Health Organization should establish advisory groups through its national and regional offices to continuously monitor the right to health through constitutions, legislation and national policies, including on financing, so as to consolidate best practices and define pathways for change. To understand how the law functions—and the removal of specific barriers can make it function better to enhance equality and dignity in health—it is necessary to convene experts within countries, as opposed to top-down mainstreaming of international law. The groups of experts in different areas of law (such as health, administrative, constitutional and tax laws), together with health economists, ethicists and civil society representatives, should regularly communicate through networks at the regional levels (for example under the auspices of the Pan American Health Organization) and WHO regional offices as well as headquarters should widely disseminate lessons learnt.

Annex A: Case studies

Benefits and challenges of domestic production using state-owned enterprises

To explain more fully how the right to health functions and is constrained in specific contexts, the report uses seven cases that provide not only geographical variety but also present differences with respect to: (i) the system of government (unitary versus federal State); (ii) source of the recognition of the right to health (constitutional right, judicial recognition, or legislation); (iii) framing of the right (right to health versus right to health insurance); (iv) public expenditure in health, and health coverage (universal health care coverage index, and out-of-pocket expenses, and); (v) the role of international institutions in influencing State behaviour.³

In each case, the report identifies key takeaways to help transform the right to health from a legal promise to an institutional reality.

TABLE 1

Cases	Type of State	Right to health	Ratified International Covenant on Economic, Social and Cultural Rights?	Corruption perception index (Transparency international) (values from 0 (highly corrupt) to 100 (very clean))	Optional Protocol to the International Covenant on Economic, Social and Cultural Rights	UHC	Out of pocket	Debt service (as % of GDP) 2021
						SDG Indicator 3.8.1 coverage of essential health services (2019)*	SDG Indicator 3.8.2. Population with household expenditures on health > 10% of total household expenditure or income (2012 - 2020)	
Albania	Unitary	Constitutional right	Ratification/Accession : 1991	35	No	62.16	16.7	1.8
Brazil	Presidential federal republic	Constitutional right	Ratification/Accession : 1992	38	No	75.03	11.8	0.6
Costa Rica	Unitary	Judicial Recognition	Ratification/Accession : 1968	45	Ratification/Accession : 2014	78	7.4	0.8
China	One party state	Legislated access to healthcare (Law of the People's Republic of China on Basic Medical and Health Care and the Promotion of Health, art. 5)	Ratification/Accession : 2001	58	No	82.17	24	0.1
India	Federal	Judicial Recognition	Ratification/Accession : 1979	40	No	61.19	17.3	0.2
Kenya	Unitary	Constitutional right	Ratification/Accession : 1972	30	No	55.95	5	1.9
Norway	Unitary state (unitary, parliamentary constitutional monarchy)	Legislated access to healthcare (multiple laws)	Ratification/Accession : 1972	85	No	85.6	no data	no data

A.

Albania (constitutional right to health care)

Albania illustrates the risk of framing the right to health as an entitlement to health insurance without regard for the structural conditions in the country. It also demonstrates the limitations inherent in recognizing legal rights within a context of structural reforms that have fostered lower public expenditure, promoted private participation in the delivery of health services (laboratories, drugs supply and diagnosis) and weakened labour rights.

The Albanian Constitution recognized the right of all citizens to enjoy healthcare provided by the State, as well as the right to health insurance in accordance with the procedures provided by law (Art. 55).

Seeking to enter the global economy after the breakup of the former Soviet Union, Albania, along with other countries in Central and Eastern Europe (CEE) passed a set of neoliberal reforms aimed at privatization, as well as making labour laws flexible and switching from a tax-based to an insurance-based health care financing model (Kaminska et al. 2021). Albania, like other CEE countries, lacked pre-communist experience with compulsory health insurance. Moreover, Albania's structural conditions (as the poorest CEE country and poor health infrastructure), made a social health insurance model ill-suited for the country (Kaminska et al. 2021; Druga 2022).

Nonetheless, on the World Bank's advice, in 1994 Albania created a compulsory insurance system that kept the contribution rate low to avoid a steep increase in labour costs (3.4% of gross salaries equally split between the employer and the employee). The compulsory insurance covered essential services and items (initially a basic list of reimbursable drugs and payments to family doctors, later the coverage was extended to primary care services and public hospital care, as well as some private hospital care and diagnostic services) (Kaminska et al. 2021). As part of the health reform, in 1995 the Government created a single purchaser, the Mandatory Health Insurance Fund as an autonomous entity to collect the contributions of employers and employees, and only covers around two thirds of the population (WHO, 2020). Uninsured people have the right to access to some services: free emergency care (since 2013), a free basic health check-up once a year (since 2015) and free visits to general practitioners (GPs, since 2017) (WHO, 2020 p xii). Albania has also privatized an array of services, including laboratory services, and brought in public-private partnerships.

The introduction of compulsory health insurance has not enabled the Albanian health care system to achieve financial sustainability, provided financial protection for the population, nor brought about the effective enjoyment of access to health care (WHO, 2020). High unemployment and informal work rates (56% of the population works in informal employment) undermine the financial sustainability of the model. The perpetual out-migration of the younger population and the aging of the remaining population compounds this, and simultaneously reduces the overall pool of social insurance contributions, thereby creating new needs for care services for elderly people.

Funding for the Albanian health system is secured through the budget of the Ministry of Health, the Compulsory Health Insurance Fund, self-generated revenues from public hospitals (used to pay salaries), and other lesser contributions from local governments (UNICEF Albania 2021). Expenditure on health as a share of the GDP is 5.23% (2018). However, private household out-of-pocket payments constitute 56% (2016) of the current health expenditure, which is the highest value in the region. Approximately 12% of households experienced catastrophic health care spending (most recent data from 2015), defined as out-of-pocket spending exceeding 40% of a household's non-subsistence spending (Gabrani, Schindler, and Wyss 2022)⁴. Among the lowest quintile, out-of-pocket expenses represent 60% of the total monthly household expenditure (Musabelliu 2019). By 2020, public financing only accounted for around 44% of the total health expenditure. The Compulsory Health Insurance Fund represents about 20% of this share (UNICEF Albania 2021) and despite the constitutional status, as of 2019 only some 62% of the population was enrolled in the compulsory health insurance, and only 50% of the poorest quintile is enrolled (Gabrani, Schindler, and Wyss 2022). It is also important to see the figures in the context of the debt servicing that the Albanian Government is forced to make, which amounts to 1.8% of GDP.

Initiatives involving European human rights institutions have helped achieve some progress in enforcing better human rights standards in the Albanian health care system. Cases before the European Court of Human Rights, for instance, revealed a lack of access to health care for prisoners and prompted the Government to take remedial measures (COE 2023). Evolving jurisprudence at the Court has also pressured Albania to review its mental health system to adequately ensure minimum safeguards against arbitrary detentions and expand coverage to Roma and Egyptian minorities, normally excluded from health services. Additionally, in dealing with complaints related to health the Albanian national human rights institution, the People's Advocate, takes a broader view of health care protections, beyond insurance. Through reports and recommendations, it has addressed the health system's needs, including inadequacies in mental health and prisoner care (Avokati popullit, 2021).

B.

Brazil (constitutional right to health)

The case of Brazil demonstrates the importance of embedding the right to health in broader structural reforms aimed at addressing social inequalities in a democratic State of law, as well as the need for the State to actively regulate private and public actors in the health sector.

In 1988, as part of the democratic transition after a brutal military dictatorship, Brazil enacted a new constitution that defined health as a universal right and a State responsibility (Castro et al. 2019). Under the Brazilian Constitution, the right to health is defined broadly to include actions and social policies in general beyond medical care (Yamin 2022). The new constitution explicitly created the unified health system—Sistema Único de Saúde (SUS). The SUS must be seen as a product of the democratic struggle; it was conceived in the 1980s by civil society as part of the ‘Health Reform Movement’ (Movimento da Reforma Sanitária) against the military dictatorship (Massuda et al. 2018).

The fundamental principles of the SUS are universality, decentralization and community participation. The principles seek to build a universal, comprehensive and decentralized health system free of charge at the point of service provision (Massuda et al. 2018). The SUS is the only truly universal health system in the world as it does not distinguish between legal residents and undocumented migrants, which is consonant with and goes beyond right to health protections as interpreted under international law. Since its creation, all Brazilians have been formally entitled to health care that is free at the point of service; there have been very significant improvements in infant and child mortality rates as well as in overall life expectancy.

The establishment of the SUS brought about reforms in health-system governance. Decentralization involved the transfer of political power and responsibility to lower levels of administration (states and municipalities) and came hand-in-hand with the creation of local health conferences and councils as mechanisms for social participation. As part of the decentralization of health, Brazilian municipalities were required to create an administrative structure (municipal health department) and assume responsibility for the co-financing of health programmes and delivery and management of health services, including specialized and hospital care (Castro et al. 2019). In addition, the SUS prompted the expansion of primary health care. Such reforms have significantly improved health service coverage, access and health outcomes, as noted above (OECD 2022a; Massuda et al. 2018; Muzaka 2018).

Nonetheless, today the SUS faces significant challenges in guaranteeing universal health care to the whole population, which has high rates of diabetes and other chronic diseases as well as diseases of poverty stemming from infections, diarrheal disease and malnutrition (Castro et al. 2019). In 2000, a constitutional amendment defined the minimum levels of financing for each level of government as 15% of revenues for municipalities, 12% for states, and a federal share according to GDP growth. Federal health spending in 2017 was 15% of net current revenue, but the newly introduced Constitutional Amendment 95 limits expenditure levels for 2018 and the next 20 years to 2017 spending levels, adjusted for inflation (Castro et al. 2019). “However, efforts to raise additional revenues such as the 1996 financial transaction tax collected specifically to fund health care, were never exclusively used for this purpose. In 2007, this tax was eliminated and no new taxes or financial instruments have been put in place to address the chronic shortfall in the sector.” Today, Brazil’s health expenditure represents 9.6% of its GDP; however, 60% is private (OECD 2022a), and comprises uncovered cosmetic and other discretionary treatments purchased by wealthier individuals as well as out-of-pocket costs for medications among low-income populations (Muzaka 2018).

States have discretion as to how they allocate their budgetary priorities, among education, health, housing and other sectors. However, under international and Brazilian constitutional law, budgetary cuts that affect fundamental rights must be strictly necessary, proportional, and must not disproportionately affect disadvantaged sectors of the population. In 2016 the Congress passed a spending cap for 20 years, and the share of health spending in the federal budget dropped 17% in 2017 alone. A constitutional amendment in 2018 then set back spending caps to 2017 levels indefinitely, both of which arguably violate non-retrogression under constitutional as well as international law (OHCHR, 2016).

One primary driver of out-of-pocket expenses is the accessibility and availability of medicines at public health facilities. According to the OECD (2022a) around one in six people who received a prescription for medication during a recent medical consultation could only obtain some of the prescribed items. This happens despite important policies implemented by the Worker’s Party (Partido dos Trabalhadores, PT) Government from the early 2000s until 2016, such as increasing the number of drugs available on the essential medicines list (from 327 in 2002 to 869 in 2017); the Popular Pharmacy Programme (Farmácia Popular), which expanded access to medicines with subsidized prices and low co-payments, and; the creation of the independent body, the National Commission (Comissão Nacional de Incorporação de Tecnologias) to support evidence-based decision making for the adoption of new medicines and technologies in the SUS.

More effective regulation of the pharmaceutical, medical devices markets and private providers could help address in part the challenges created by new high-cost medicines and the use of new technologies, claims for which involve intensive litigation⁵. Additionally, an effective measure to combat tax evasion could provide more resources to the Federal Government to use on health.

The underfinancing of the SUS, together with the system's heavy emphasis on treating human conditions and problems as medical conditions, and the transformation of such conditions into targets for pharmaceutical intervention, have contributed to health inequities across socio-economic groups and geographic regions. For example, remote municipalities in the North and Northeast regions consistently present poorer health outcomes and lower care quality than the wealthier South and Southeast (Massuda et al. 2018; da Mota Almeida Peroni et al. 2019). Public health initiatives, such as the Family Health Strategy and the More Doctors Program, to improve service availability outside urban areas proved too small to narrow this gap (Mullachery, et al 2016; Mendonça, et al 2018; Gonçalves, et al 2016).

Despite ongoing challenges, the SUS is highly valued by Brazilian society, which sees it as a core social institution and an institutional symbol of the aspirations of the 1988 transformative constitution (Castro et al. 2019). The right to health has remained a focal point in establishing continuity and preventing greater deficits during periods of austerity and governance crises. While it cannot provide an absolute shield against all problems related financing and political instability, the constitutionalization of the right to health has presented unique opportunities for accountability and public intervention against discriminatory measures, in favour of a more equitable system. The right was also central to judicial decisions on the recognition of the obligation to have inclusive health systems for the transgender community and injunctions for indigenous peoples and other ethnic minorities at most risk during the COVID-19 pandemic (Bottini Filho 2021). Regulation and decisions on consumer contractual rights under the right to health have also had an impact on the private health market.

C. Costa Rica (judicial construction)

The case of Costa Rica shows the importance of a universal system that emphasizes primary care to institutionalize a right to health, while also signalling the importance of transparent and participatory mechanisms to make and implement health decisions. Users of the health system have the right to know the reasons behind the decision regarding treatments included in their health packages; in other cases, even in cases such as the Costa Rican one, with comprehensive health coverage, lack of trust can challenge this, undermining the capacity of the health system.

Costa Rica has one of the oldest Latin American democracies, politically independent courts, and a rights-friendly constitution (Wilson 2009). The country also stands out for its commitment to universal health care access. At the beginning of the 20th Century, national legislation established the State's responsibility to ensure and improve public health. Created in 1941 the Costa Rican Social Security Fund (Caja Costarricense de Seguro Social) is an autonomous institution in charge for the administration of the funds derived from mandatory contributions from employees, employers and the State. The funds cannot be used for purposes other than those for which they were created.

Costa Rica's 1949 Constitution does not contain an explicit right to health; the Constitutional Chamber of the Supreme Court (known as Sala IV, and created in 1989 by constitutional amendment) has derived a right to health from the right to human life (art. 21), the right to protection of health, environment, security and economic interest of consumers (art. 46), the duty of the State to guarantee wellness (art. 50), and the right to social security protection (art. 73) (Organización Panamericana de la Salud 2019; Norheim and Wilson 2014). Using litigation to benefit from this judicially constructed right has provided Costa Ricans access to medical care denied by the Caja, beginning with antiretroviral drugs in the 1990s and extending to a wide range of medicines and care (Wilson and Gianella, 2022).

Judicial enforcement of health entitlements through protection writs (amparos) is primarily driven by people seeking access to medications, and opaque priority-setting processes. Costa Rica's legal framework guarantees the right to universal health care for all inhabitants and entrusts the State with the primary responsibility of ensuring this right. However, according to a recent national household survey, 14.9% of the inhabitants do not have access to health coverage (a percentage higher than what the Caja reported), and undocumented migrants are at heightened risk of lack of access to health insurance. Lack of health insurance disproportionately affects certain sectors: construction workers (30.6%), domestic workers (25.3%), and mining (25.3%) (Pacheco Jiménez and Alvarado-Prado 2022).

The bulk of funding for the health system comes from mandatory contributions. In the case of employees under payroll, three parties share the cost: employers (9.25%), employees (5%) and the State (0.25%). In the case of retirees, the cost share is similar, 5% is equally divided among personal savings, the pension fund and the State directly. Non-payroll workers, who account for 47% of total workers, contribute 2.89%–10.69% of their income, and the State pays 0.25%.

Although the country's investment in health as a share of the GDP is above the regional average, a confluence of factors are challenging the system's financial sustainability. Firstly, population aging means that by 2019, 11.5% of the population

was 65 or older, a percentage that could reach 13.8% by 2032. Older people make more intensive use of clinical services and have higher rates of chronic diseases. Secondly, the epidemiological transition in the population as a whole has triggered an increase in the rates of non-communicable diseases that are costly to treat. Thirdly, the increasing costs of health technologies and intellectual property in pharmaceuticals is a global problem that exacerbates financial strains.

Within Costa Rica, the health sector has mounted a resistance to the judicial enforcement of health-related rights claims, which is seen as impinging on the political authority of the Government to establish priorities and manage the system efficiently. The Caja stresses the lack of knowledge of judges to decide on medical treatments. At the behest of the World Bank Institute, in 2014, the Sala IV introduced a policy innovation to respond to such criticisms. This involved partnership with the Cochrane Collaboration (now “Cochrane”) to incorporate medical expert evaluations into its decision-making process for claims seeking access to medications (Instituto del Banco Mundial 2012; Pinzón-Flórez et al. 2016). Some studies have shown that this partnership has reduced the percentages of rulings granting access to experimental drugs, and increased the success rate for non-experimental medicines (Loaiza et al. 2018). However, Cochrane’s overall impact on the health system’s fairness appears marginal (Luciano and Voorhoeve 2019).

The marginal influence is likely attributable to the fact that litigation itself is not the problem; it is a symptom of larger structural problems concerning the legitimacy of health decision making and trust in the Government. Even if Costa Ricans enjoys good health care, compared with countries of similar income levels, Costa Ricans also have a high level of distrust in its authorities, reflected in a high percentage of the population that perceives the authorities as corrupt. In a context with high levels of distrust, health prioritization processes that lack open spaces for broad public participation, feed discontent and appeal to other mechanisms to vindicate rights (Transparency International, 2021).

D. The People’s Republic of China (health system reform towards universal health coverage and legislation recognizing the right to health)

The case of the People’s Republic of China shows how countries that lack a constitutional right to health can nonetheless undertake significant reforms to improve health outcomes, and to adopt a rights discourse in their health policies, while at the same time underscoring the limitations of promoting reforms through top-down processes in autocratic contexts.

In the last 25 years, the People’s Republic of China has implemented ambitious reforms to increase health insurance coverage among its population. To this end, working successively with different target populations the country introduced three different insurance schemes: i) the Employee Basic Health Insurance, targeting formal workers in 1998; ii) the New Cooperative Health Scheme (NCMS), which provided subsidized health insurance for the rural population in 2003; and iii) the Urban Workers Basic Health Insurance for poor urban people and informal sector workers in 2007. Later in 2009, the country started a comprehensive health care system reform to establish “an equitable and effective health system for all people (universal health coverage) by 2020 by strengthening healthcare delivery, health security, and provision of essential medicines” (Meng et al. 2019). As part of this reform, the People’s Republic of China increased both the scope of service packages and financial protection. Today, the country has two principal basic health insurance schemes targeting (i) rural populations and (ii) poor populations from urban areas. Both are funded primarily by Government subsidies (approximately 70% of the total funds) and workers’ mandatory health insurance financed by employer and employee contributions (Meng et al. 2019). Additionally, since 2015, there is an insurance to cover catastrophic illnesses, extending financial protection for families at risk of being impoverished by health expenditures.

Public health care is central to the Government’s concerns. Reforms implemented since 2009 have produced positive results, which show the authorities’ long-term commitment to UHC: the country has achieved near-universal health insurance coverage (see Table 1), the basket of services offered by insurance schemes has gradually expanded, and out-of-pocket expenses have fallen (World Bank and WHO 2019). In addition, insurance has increased the use of health services, including annual medical check-ups and services for public health priorities that are either free or almost free.

The Chinese Government has also invested in strengthening primary health care infrastructure. Finally, the authorities have adopted in the legislation, the right to health, which is a milestone for the country. Despite such positive outcomes, the country’s health-system reforms have not addressed some critical issues, including the low quality of care, especially in primary health care facilities in rural and poor areas (Meng et al. 2019; World Bank and WHO 2019). There is also a lack of effective State policies to attract and maintain qualified health workers at primary health facilities (Meng et al. 2019). The shortage of skilled health workers at primary health facilities undermines the health system’s capacity to accomplish the functions of prevention, early detection and the timely referral of cases (World Bank and WHO 2019). Unequal access to health care affecting rural populations and ethnic minorities (Yan et al. 2020; Gilmour et al. 2022) is also a significant challenge that needs to be addressed.

Notwithstanding such progress, the overuse of inpatient services is of significant concern. The Chinese health system is biased towards admitting patients to hospitals rather than treating them at the primary care level, and delivering more treatment rather than improving population health outcomes (World Bank and WHO 2019). Public hospitals account for over 60% of total health expenditure (Meng et al. 2019), and the country's hospital admission rate is higher than the average of OECD countries. Inpatient care is far more expensive than outpatient care but medical costs for inpatient and outpatient services have both increased, undermining the financial protection provided by health insurance, especially for poor households (Meng et al. 2019).

In 2019, the State Council of the People's Republic of China issued the Healthy China Initiative 2019–2030, which proposed measures to popularize health knowledge, participate in health actions, provide health services and prolong life expectancy (Zhang et al. 2020). The enactment of the Basic Healthcare and Health Promotion Law by the Standing Committee of the National People's Congress of China in 2019 was a milestone in the quest for UHC and the right to health in the country.

This Law, which entered into force on 01 June 2020, recognizes the right to health (which the Chinese Constitution does not mention) as a citizen's right to be upheld by both State and society (Ip 2020). In Article 4, the Law states that “the state and society respect and protect citizens' right to health”. Article 5 states “citizens shall, in accordance with applicable laws, have the right to receive basic medical and healthcare services from the state and society”, and Article 15 codifies that the State has to provide essential public health services free of charge. The law also provides for (Article 11) the prioritization of State investment in areas with large ethnic minority populations, border areas and poor areas. Further, while it is recognized that Government-run medical and healthcare (Article 29) will provide most of the basic medical services, the law also encourages the private sector to participate in delivering basic medical care. The impact of the law is yet to be seen, and the COVID-19 pandemic, which had far-reaching consequences for the Chinese health system, have made it difficult to assess effects.

The system's accountability poses another major challenge. Reforms in the People's Republic of China are known for being top-down, designed and adopted by high-ranking officials behind closed doors. There are no guarantees for citizens' participation in health decisions. Accountability is a precondition of any meaningful right to health to establish mechanisms for affected populations' participation and input. And it is particularly important in a country where marginalized groups, including rural people and ethnic minorities, face significant barriers in access to quality health care.

Additionally, to achieve UHC the People's Republic of China must increase public spending on health which is still very low, at around 4% of GDP, and, in parallel, implement measures to improve the allocation of health care expenditure (for instance by reducing the overuse and misuse of inpatient care, and improving the quality of primary health care). This is a context where the authorities, and international actors, promote greater participation by private actors in the delivery of health services (currently, almost all health services are provided by public institutions). In order to contain costs and reduce inequities it will be necessary to adopt measures to address the Chinese health system's preference for inpatient services and complex care.

E.

India (judicial construction of the right to health)

The Indian case illustrates the important symbolic as well as extra-territorial impacts of a judicially constructed right to health care, while also revealing the limitations of judicial power to catalyze broader policy changes that the Indian Government would need to make to transform access in practice.

Indian courts have engaged with the right to health with numerous decisions and have gradually fleshed out the notion and the bounds of a constitutional obligation to provide free health care. However, this set of jurisprudence has not been reflected in broader policy reforms that would transpose those individual rulings into a functional and equitable health system for all local administrations (Amhed et. al, 2020, Selvaraj et. al., 2022). Just as decisions are sparse through different judicial declarations, health care is equally a patchwork operating at multiple regional levels without a central cohesive policy to ensure equitable access to health care. One institutional obstacle is the lack of institutional measures or legislation giving a framework of the right to health in equitably funded, as well coordinated, countrywide welfare policies (Amhed et. Al., 2020; Selvaraj 2022).

During centuries of colonial occupation, the British developed significant public health programmes to control infectious diseases, carry out disease surveillance and create surgical facilities and mental asylums, among other things. Colonial occupation of India yielded an extraordinary amount of knowledge on the nature and control of infectious diseases, including leprosy, cholera, tuberculosis, Kala-azar, malaria and the plague. The Colonial medical system in India unquestionably improved sanitary measures and health outcomes, but the “archetypical Colonial design of medical services, Eurocentric policies, and neglect of the indigenous population failed to relieve the plight of the poor” and formed the basis for the trajectory of the post-independence Indian health system. (Mushtaq 2009)

Today, the Indian health system is characterized by fragmentation, underfinancing and poor quality public health care, the private sector's inordinate participation (about 70% of all outpatient visits and about 58% of hospitalization visits occur in private facilities), and weak capacity to provide financial protection against health expenses. Private expenditure contributes over two-thirds of India's health spending, with the national and state governments financing only about one-third of all health spending (Selvaraj et al. 2022); out-of-pocket expenses in India account for 62.6% of total health expenditure, one of the highest in the world (Sriram and Khan 2020). India spent 275 international dollars per capita on health in 2018, one of the lowest expenditures among south Asian countries, that was below those of lower-middle-income countries.

Total health expenditure as a percentage of the GDP has hovered around 4% in recent years, while the Government spent about 30% as a share of total spending in the same period. In terms of placing a priority on health within the overall Government budget, India spends 3% on health out of its total government expenditure, which is lower than countries such as Indonesia, the People's Republic of China and Thailand (Gupta 2022).

Despite such poor financing, India has created programmes and policies to increase health care coverage. One of these is the National Health Policy from 2017, which provides an explicit framework for achieving UHC. There are also fully subsidized health insurance schemes targeting poor people, some financed by the national Government and others by state authorities. The first was the Rashtriya Swasthya Bima Yojana (RSBY), launched by the Ministry of Labour and Employment in 2008, and later transferred to the Ministry of Health and Family Welfare. In 2018, a new national health insurance—the Pradhan Mantri Jan Aarogya Yojana came into being, replacing the RSBY. The new health insurance seeks to cover 500 million from poor, economically and socially disadvantaged groups (Selvaraj et al. 2022). Like other public health insurance programmes, the scheme focuses on inpatient services. Research has shown that having public health insurance increases the likelihood of hospitalization (use of inpatient services). However, the restricted coverage does not encourage the use of outpatient services and primary health care (Sriram and Khan 2020).

The 2017 National Health also prompted the creation of Health and Wellness Centers (HWCs), health facilities able to provide comprehensive primary health care packages including geriatric, palliative and rehabilitative care. By February 2022 there were 90,808 HWCs established across the country, improving the availability of health facilities, and reducing inequity. While it is still too early to assess the impact of this policy on population health, early evaluations attest to the central Government's commitment to the timely transfer of funding to states for the operation of HWCs.

In addition to the urgent need to improve accessibility to public health care at all levels, and enhance the quality of the care provided in public services, India faces the considerable challenge of improving the regulation of the private sector. Corruption is rife as result of marketization, along with poor oversight and regulation. In India, a broad range of private providers, from for-profit to non-profit services, individual practitioners to hospitals, are subject to various regulations with multiple levels of compliance. To regulate the quality of care delivered by the private providers, the Indian Government issued the Clinical Establishments Act 2010, whose aim was to enforce common minimum standards of quality for diagnosis and treatment, which requires registration for all types of health facilities. However, most Indian states have not implemented the Act (Selvaraj et al. 2022).

India has been using litigation as a mechanism to improve health care. Since the 1980s the Supreme Court, adopting a liberal interpretation of its powers of review, has issued several landmark judgments awarding compensation for violations of rights related to health (Parmar and Wahi 2011). Currently, the Indian Constitution does not include a provision on the right to health. However, in its rulings, the Supreme Court has linked the right to health to the right to life (under Article 21 of the Indian Constitution). In 1996, the right to health became independently justiciable when the Court stated that the right to health was integral to the right to life. Litigation on health rights has a reputation for influencing deliberations on and the adoption of policy across a wide array of areas: the regulation of blood banks and of drugs, emergency care, mental health care, medical negligence and malpractice by public entities, and reproductive rights. In each of these instances, courts have identified regulatory and policy gaps as well as noncompliance, which prompted Government initiatives. However, the Indian Supreme Court has not outlined clear minimum obligations encompassed by the right to health. Enforcement of the rulings is yet another constraint to litigation on health rights in India. The Court cannot impose penalties for noncompliance with judicial decisions (Parmar and Wahi 2011). There is no evidence of a correlation between the Indian Supreme Court's recognition of the right to health and attempts to increase public health expenditure, which is critical to improving the accessibility, availability, affordability and quality of healthcare in India.

In spite of such shortcomings, litigation has been driving the debate on access to medicines, and intellectual property rights. The Indian Supreme Court, together with other courts, such as the Delhi High Court, have issued landmark decisions for intellectual property cases that have ramifications, not just for India but the entire world. Indeed, the right to health can have transboundary consequences and curb the power of transnational pharmaceutical corporations. While India has long played a key role in supplying quality low-cost and generic pharmaceuticals, including for HIV/AIDS, multilateral and bilateral trade agreements can undermine its capacity to manufacture and sell the drugs on local markets as well as abroad (Plahe and McArthur 2021).

F.

Kenya (constitutional right)

The case of Kenya reveals that lower-middle-income countries can make efforts to progressively realize the right to health, and lays bare the constraints they face in financing a robust health care system.

Kenya obtained independence from the United Kingdom in 1963. During the Colonial period, the British Government assumed health care responsibilities through the Imperial British East Africa Company. Health care was initially provided to indigenous Kenyans only in the case of outbreaks of infectious diseases. In the 1920s after massive losses of lives to famines and diseases of poverty, dispensaries were created and staffed by Kenyans trained in western medicine by British medical officers (Beck 1970). Kenya maintains a strong tradition of Western mission medicine, overwhelmingly financed and managed by international religious institutions (Kagawa et al, 2012).

Kenya's health financing also continues to be highly aid-dependent, including on the United Kingdom. Donors and NGOs pool funds to strategic health programmes and services, such as those aligned with global development goals (for example malaria, HIV/AIDS, and tuberculosis, and maternal and child health).

In 2010, after a period of brutal civil strife, Kenya enacted a new constitution that explicitly recognizes (Art 43) the right of every person to the highest attainable standard of health, which comprises the right to health care services—including sexual and reproductive care—to enjoy reasonable standards of sanitation, access to safe and clean water, as well as to be free of hunger. The constitution also lays out (Art. 21. 2) the duty of the State and State bodies to take legislative, policy, and other measures for the progressive realization of rights under Article 43, including addressing the needs of vulnerable groups within society and the international obligations regarding those

rights. However, the duties are framed as programmatic and not linked with predetermined rules of health care expenditure (as part of the national expenditure). Judicial interpretations of rights remain heavily influenced by British law from the colonial period, unlike organic efforts that have emerged from social movements (for example the Health Movement in Brazil), the articulation of the right in the Constitution is taken directly from that used by the Committee on Economic, Social and Cultural Rights, revealing the lingering effects of colonialism in international law itself.

The 2010 Constitution also reformed governance in ways that directly affect health care delivery. One critical reform involved allocating health functions to the 47 county governments. Under the new legal framework, the national Government is responsible for the leadership of health policy development; managing national referral health facilities; capacity building and technical assistance for counties, and; developing norms, standards and guidelines. For their part, county governments are responsible for county health services, including county health facilities and pharmacies; ambulance services, and; promoting primary healthcare (Republic of Kenya 2022; Mbindyo et al. 2020; Republic of Kenya 2020). In this new structure, which creates shared responsibilities between the national and county governments, a percentage of resources go directly from the National Treasury to the Ministry of Health to finance health activities. From the Ministry, the resources are transferred to the counties. In the health system, the national and county governments are both responsible for purchasing.

In 2017 the General Health Act was passed. This law provides the content to the constitutional right to health, as well framing the role of the State in actualizing the right. Under the General Health Act, the right to health includes the right to access promotive, preventive, curative, palliative and rehabilitative services. The Act recognizes dignity, respect and privacy as core to the realization of the right to health. It also stipulates that the constitutional right to health obliges the national and county governments to provide free maternal and child services. The past is littered with cases of women being detained in facilities for non-payment of delivery fees, which courts have found unconstitutional.⁷

In general, research has shown that despite the constitutional recognition of the right to health, programmatic and policy efforts deployed by the Kenyan Government (such as the elimination of user fees at higher levels of health facilities and primary and maternal healthcare), the incidence of catastrophic payments is still high, and even higher among the poorest households and in the rural areas. The primary driver of out-of-pocket payments is outpatient services (Salari et al. 2019). Decentralization has not involved sufficient efforts to align financing responsibilities with control over procurement and resource allocation.

Indeed, the Kenyan health system stands out for the very wide range of stakeholders involved in financing, and the number of different sources that feed the pool of resources, including the national Government, county governments, donors, private sector providers and counties (Mulaki and Muchiri 2019). The national Government pools taxes and other revenues to fund Ministry of Health functions, three large tertiary hospitals, strategic health programmes and counties. In the case of county governments, the pooled resources come from shareable revenue, conditional grants, and locally generated revenues to fund county social services, like health, including in theory free primary and maternal health care. Each county individually and independently determines how much to allocate for health services according to its mandates and priorities (Republic of Kenya 2022). Data show that some counties have increased their allocations to health while others have reduced them, thereby exacerbating inequities (Republic of Kenya 2022).

However, since 2020 donor contributions have dropped, and external funding as a proportion of total health expenditure has declined by about 10%. As a result, the Government has increased its financing of strategic services. In the 2020s, annual government health spending has accounted for approximately 6% of total government expenditure, but the increases are insufficient to fill the financial gap left by the decline in donor support. At the same time, the Government is required to pay 1.9% of GDP toward servicing its debt.

The Kenyan National Hospital Insurance Fund (NHIF) is the oldest government insurance scheme in Africa, and functions as the purchasing entity for inpatient curative and rehabilitative services. The NHIF pools resources from mandatory payroll deductions, voluntary contributions and government subsidies to pay for defined services at public and private hospitals, including in theory free antenatal and postnatal care (under the 'Linda Mama' programme). Despite such programmes, out-of-pocket expenses account for 27.7% of the total health expenditure. Efforts to expand the NHIF are under discussion.

Kenya presents a poor case for social insurance as a mechanism for financing the right to health because there is such a large informal sector and unemployment. Government figures put the unemployment rate at 36%. Besides, 85% of the labour force is in the informal labour market (Republic of Kenya 2022).

After over 10 years of the constitutional recognition of the right to health, a significant proportion of the Kenyan population does not enjoy it. Owing largely to the poor underlying infrastructure, lack of funding and poor oversight of the complicated health system, the promises made in the constitution remain just that.

G.

Norway (Legislation recognizing access to health care and patients' rights)

The Norwegian case illustrates the important role priority-setting plays in creating a health system, which is consistently described as comprehensive and impressive in terms of outcomes, even in a context of tremendous resources (OECD 2014).

Norway has one of the highest per capita GDPs in the world and one of the highest health care expenditures (as a percentage of the GDP) in the European region (10.5%). In addition, Norway scores well on health indicators, partly attributed to the comprehensive mandatory health insurance accessibility, and the accessibility and quality of health care services.

Universal health coverage in Norway has a long history. In 1909, the Health Insurance Act entered into force, which created mandatory coverage for low-income employees and their families. In 1956, the compulsory health insurance was converted into a universal and mandatory right for all residents (Haddeland 2019). Additionally, workers in permanent or movable installations on the Norwegian continental shelf have compulsory insurance, as do some Norwegians working abroad (Sperre Saunes, Karanikolos, and Sagan 2020).

Norwegian mandatory health-insurance coverage is comprehensive and has sustainable funding, which distinguishes it from virtually all other health insurance funds in the world. It includes a broad range of services for legal residents, including services provided by general practitioners, physiotherapists, preventive services including check-ups, screening, and the immunization of infants and school children. It also includes preventive mental health services (mainly for children and adolescents); approved prescription drugs, nursing care within and outside institutions (including long-term care), dental care for children and a few selected groups; medical eye care (glasses are usually excluded), most specialist ambulatory and hospital care, emergency care, including emergency after-hours specialist care (Sperre Saunes, Karanikolos, and Sagan 2020; Helsedirektoratet 2020).

General taxation (national, county, and municipal tax revenues) is the primary source of financing (76%), reflecting and reinforcing the principle that health care is part of the social contract. In addition, some funds come from mandatory contributions to the National Insurance Fund (10%) and out-of-pocket payments (14%) (Sperre Saunes, Karanikolos, and Sagan 2020). Out-of-pocket payments include cost sharing of services (such as appointments with general practitioners) and direct payment for services not included (such as general dental care for adults). However, to avoid catastrophic health expenditure and guarantee the financial protection of the population, there are annual cost-sharing ceilings. No cost-sharing is required for inpatient and long-term home-based nursing care. This measure has allowed Norway to keep its out-of-pocket payments among the lowest in Europe, although there is increasing concern about the potential financial impact of incorporating high-cost medications and therapies.

In addition to its comprehensiveness, quality and stable funding, the Norwegian health system stands out for its efforts to be transparent in how it sets priorities and makes decisions. Transparency in the health care system has been a political priority. Norway has a system that publicly monitors performance indicators in policy processes (Sperre Saunes, Karanikolos, and Sagan 2020). Additionally, it has made efforts to establish a fair, transparent and accountable priority-setting process. Under the Norwegian health insurance system, all Norwegian citizens can be considered legitimate stakeholders for priority setting (Solberg, Tranvåg, and Magelssen 2022).

In 1985, the first Norwegian priority-setting committee came into being with the realization that technological innovation required an in-depth assessment of the correlation between medicine, ethics and economics (Ottersen et al. 2016). In 1987, the Committee issued the first white paper on priority setting, and since then, Norway has had four more white papers and one working group on priority setting in health care services. Norway applies three formal criteria to priority setting, which must be considered together (rather than in isolation). The first is the health benefit criterion; interventions that are likely to generate greater benefit get higher priority. The second is the resource criterion; more priority is given to interventions that require fewer resources. The third criterion, recommended by the First Committee in 1987, concerns the severity of the disease; more priority is given to interventions that target more severe conditions. The three criteria apply to groups and individuals alike and are enshrined in laws and regulations (Solberg, Tranvåg and Magelssen 2022).

A study carried out in 2019 shows that the majority of Norway's citizens are willing to use a large share of public resources on health (and even ask to increase public health care funding). They accept priority-setting processes put in place by the Government (Solberg, Tranvåg, and Magelssen 2022). Transparent priority setting has generated trust and confidence in the health system as a valued core institution. Such trust was highly visible in Norway's successful navigation of the COVID-19 pandemic.

Norway's commitment to equal access to health care is reflected in the whole system. While it is true that the country has one of the highest GDP per capita and public expenditure in health in the world, it is also true that the success of UHC in Norway is deeply rooted in social values and commitment to equality that is reflected in legislative frameworks (including the Patients' Rights Act) and the organization of the whole health system. The Norwegian health authorities' concern about whether the people consider the health system's decisions legitimate shows the authorities' commitment to being held democratically accountable. It also underscores the centrality of health care to the functioning of Norway's social democracy.

Annex B:

Matrix of constitutional recognition of the right to health

To illustrate the vast differences in how countries understand the right to health, constitutional texts were coded according to references to different concepts. However, it is patently misleading to assess States based on snapshots in time because constitutions undergo frequent amendments, legislation and judicial interpretations of health and, indirectly, related rights evolve—and health systems continually go through reforms. The scope of this report requires limiting the catalogue of constitutional provisions to those directly related to access to health care or public health services as of 01 December 2022. The coding of constitutional texts followed the rules and definitions appear below.

Basic medical services: textual references that describe an essential level or only emergency health care services;

Free care: textual references to health care services free of charges;

Programmatic aspirations: provisions related to health that are described as goals or policies which the State should undertake, but are not described as an individual or collective enforceable rights, or merely appear as a declaration or principle that the State should broadly take into account;

Provided by law: a conditionality or clause that subjects the realization of rights or policies to further legislation or regulation;

Public health: content and themes described within State policies and responsibilities that concern health at the population level—not restricted to treatments or medical care—involving the prevention of diseases and epidemiological surveillance, through measures to promote health or reduce health risks.

The database is available upon reasonable request.

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Acknowledgements

Dr Ritu Sadana, Head, WHO Secretariat supporting the Economics Council, coordinated and guided this work. Alberto Garcia Huitron, research consultant, within the WHO Secretariat supporting the Economics Council, provided research support.

The World Health Organization and the Council on the Economics of Health for All acknowledges financial support from the Government of Finland enabling the Council's research activities and stakeholder engagements.

The WHO Council on the Economics of Health for All was established on 13 November 2020 to provide guidance on the economics and health agenda of WHO. It is an independent council convened by Dr Tedros Adhanom Ghebreyesus, WHO Director-General.

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