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A Right to Universal Health Coverage in Resource-Constrained Nations? Towards a Blueprint for Better Health Outcomes

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A RIGHT TO UNIVERSAL HEALTH COVERAGE IN RESOURCE-CONSTRAINED NATIONS? TOWARDS A BLUEPRINT FOR BETTER HEALTH OUTCOMES

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Abstract

Universal health coverage, as conceived by the World Health Organization (WHO) and adopted in the programmatic framework of the Sustainable Development Goals (SDGs), is a clarion call for states to strengthen their health financing systems to avoid catastrophic and impoverishing health spending. However, the framing of the goals of universal health coverage fails to take account of underlying determinants of health and appears to abandon decades of health rights scholarship and jurisprudence. This scholarship and jurisprudence, although not entirely free from disagreements and shortcomings, is argued to offer a better framework for universal health coverage when strengthened with the paradigm of legal positions developed by Robert Alexy. Informed by the need to bolster universal health coverage to ensure better health outcomes in resource-constrained nations such as Brazil, India, Nigeria and South Africa, this paper argues for a strengthening of the framework of the right to health and its convergence with universal health coverage to achieve better health outcomes in resource-constrained nations.

I. IN THIS PAPER, I advance the claim that if the "right to health", understood as a set of "legal positions" to universal health coverage, is implemented in resource-constrained nations, better health outcomes are likely to result. The means I suggest for the implementation of the right is by engaging the tripartite framework of legal positions developed by Robert Alexy to clarify the beneficiaries, subject matter and addressees of the right to health. Alexy's idea bolsters the current framing of universal health coverage, linking it with the underlying determinants of health; and seeking a convergence of the right to health and universal health coverage to inform the attainment of better health outcomes in resource-constrained nations. The better health outcomes I envisage include significant reductions in the mortality rates, morbidity ratio and communicable and non-communicable diseases, and improvements in the underlying determinants of health.

By putting forward these arguments, I invariably suggest that the current framing of the right to health in international law, and the domestic system of many resource-constrained nations, is inadequate to bring about the attainment of better health outcomes in those states. I further suggest that universal health coverage, as currently framed by the World Health Organization,

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WHO, and in the programmatic framework of the Sustainable Development Goals (SDGs)[1] is too narrowly focused on clinical outcomes to the detriment of the underlying determinants of health which play a significant role in securing the better health outcomes that I advocate in this paper.

In Part II, I clarify three concepts germane to the paper, namely, "the right to health", "universal health coverage" and "resource-constrained nations". In Part III, I examine Alexy's concept of legal positions and suggest ways in which his tripartite paradigm of *beneficiaries*, *subject-matter*, and *addressees* can strengthen the right to health. I focus specifically on the constitutional context of India and Nigeria, where the right has been weakly framed vis-à-vis Brazil and South Africa where the right is strongly framed. I then return to the discussion on universal health coverage in Part IV where I point out the problem with its current framing. I suggest ways it can be strengthened by integrating underlying determinants of health into its framework. I also make a case for its convergence with the right to health to bring about better health outcomes. In Part V, I offer, by way of conclusion, a summary of the main claims advanced.

II. THE RIGHT TO HEALTH, UNIVERSAL HEALTH COVERAGE AND RESOURCE-CONSTRAINED NATIONS : SOME PERTINENT CLARIFICATIONS

A. THE RIGHT TO HEALTH

More than 70 years since the emergence of the "right to health" in international human rights thought and action,[2] there remains significant disagreement about what the right means, its content and the best way to bring about its fulfilment. These disagreements have largely hindered the effective deployment of the right in international law and in many domestic legal systems. It is for this reason that I suggest that the framework of the right to health needs to be first strengthened by recasting it as a set of legal positions so as to properly clarify the nature of the obligations which claims about the right to health implicate. Thereafter, I advocate for the convergence of this

[1] See *Transforming Our World: The 2030 Agenda for Sustainable Development*, GA Res 70/1, UNGAOR, 17th Sess, Supp No 49 (2015) 3; World Health Organization, *Health in 2015: From MDGs, Millennium Development Goals to SDGs, Sustainable Development Goals* (Geneva: WHO Press, 2015).

[2] The preamble to the *Constitution of the World Health Organization 1946* (WHO) was the first international legal instrument to expressly provide for the right to health. Since then, it has been codified in several other international instruments (such as the International Covenant on Economic, Social and Cultural Rights 1966) and has informed international human rights praxis in the area of health, internationally and domestically. See *Constitution of the World Health Organization,* 22 July 1946, WHA51.23 (entered into force on 7 April 1948) (*WHO Constitution 1946)*.

revitalized paradigm of the right to health with universal health coverage in order to achieve better health outcomes in resource-constrained nations.

Scholarly debate about the meaning of the right to health stem from disagreements about the way health has been defined in the preamble of WHO Constitution as "…a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[3] The principal objection to this formulation of the right is that the inclusion of "social well-being" in the definition of health has turned "the enduring problem of human happiness into one more medical problem to be dealt with by scientific means."[4] Another objection to WHO conception of the right is that it "obscures some relevant moral distinctions that need to be taken seriously in the process of specifying rights and duties regarding the right to health."[5] Although General Comment No. 14 of the Committee on Economic, Social and Cultural (CESCR) has largely addressed some of these objections,[6] questions remain on mapping out the exact contours of the right.

The complication about what should rightly be canvassed in claims about the right to health is exacerbated by the precatory formulation of the right in the *International Covenant on Economic, Social and Cultural Rights*, ICESCR.[7] This is in contrast to the dogmatic formulation of counterpart rights in the *International Covenant on Civil and Political Rights*, ICCPR.[8] In many resource-constrained nations where the right to health has been incorporated into the national constitution (Nigeria and India inclusive), the framing of the right has been followed by constitutional provisions that exclude the justiciability of the right.[9] Some resource-constrained nations, such as India, have found a way around non-justiciable constitutional provisions on health

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[3] *Ibid*. Preamble to *WHO Constitution 1946*.
[4] Daniel Callahan, "The WHO Definition of Health" (1973) 1:3 Hastings Center Stud 77 at 80.
[5] Thana Cristina de Campos, "Health as a Basic Human Need: Would This Be Enough?" (2012) 40 , Med & Ethics 251 at 254.
[6] General Comment No 14 clarifies that the right to health does not mean the right to be healthy. Rather it suggests a claim as to availability, accessibility, acceptability and quality of health goods and services. See Committee on Economic Social and Cultural Rights, *General Comment No 14: The Right to the Highest Attainable Standard of Health (Art. 12)*, 22nd Sess, Un Doc E/C.12/2000/4 (11 August 2000) at paras 8 and 12. [Committee on Economic Social and Cultural Rights]
[7] *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) arts 2 and 12; see also Alicia Ely Yamin, "Defining Questions: Situating Issues of Power in the Formulation of a Right to Health Under International Law" (1996) 18 Hum Rts Q 398 at 404.
[8] See *International Covenant on Civil and Political Rights,* 19 December 1966, 999 UNTS 171 (entered into force 23 March 1976) art 2; see Yamin, *supra* note 7.
[9] See *Constitution of Nigeria* s 17 which provides for the right to health, and s 6(6)(c) which renders the right non-justiciable; see also *Constitution of India* arts 39(e), (f) and 47 which provide for the right to health, and art 37 which renders the right non-justiciable.

(and other socio-economic rights) to achieve a measure of justiciability.[10] Others, such as Nigeria, have largely refrained from doing so, adopting instead an attitude of ambivalence towards the right.[11] I explain this phenomenon (elsewhere) as stemming from the fact that the human rights norm on health that the constitutional framework of Nigeria has radiated does not demonstrate a sufficient level of commitment to the right.[12] As such, the Nigerian populace have not been well positioned to secure for themselves sufficient guarantees of enforceability of the right to health.

The difference between Nigeria and India is that while the apex court of the former has been largely timid in expounding the jurisprudence on socio-economic rights,[13] the apex court of the latter has adopted an activists stance that has resulted in a paradigm shift in how the right to health (and other socio-economic rights) are regarded.[14] On this basis, it is possible to hold the view that health rights litigation is perhaps an effective strategy for overcoming the shortcomings of the right to health. On this view, one may in fact argue that we need to focus our efforts on how to make the right to health justiciable and discontinue the paralyzing debate about how to strengthen the framework of the right. However, this argument is not without its own *paralyzing flaws.* Elsewhere, I have argued (drawing from the scholarship[15] and jurisprudence in this area),

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[10] In *Mullin v Delhi* (1981) 2 SCR 516 [Supreme Court of India] a case dealing with deplorable prison conditions, the Supreme Court interpreted the right to life to include the right to live with human dignity and all that goes along with it, include bare necessities of adequate nutrition, clothing and shelter. Developing along this trajectory, in 1997 the Court affirmed the settled position of law in India that the right to health is integral to the right to life in *State of Punjab v Chawla* (1997) 2 SCC 83 [Supreme Court of India] a case dealing with constitutional obligation to provide health facilities to government workers under art 21 when read with Directive Principles of State Policy under arts 39(c), 41 and 43.

[11] Despite the incorporation of the *African (Banjul) Charter on Human and Peoples' Rights,* 27 June 1981, OAU Doc CAB/LEG/67/3 rev 5, 21 ILM 58 (entered into force 21 October 1986) into Nigerian domestic law by the *African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act 1983* (Nigeria) there remains a measure of uncertainty as to the status of the right to health vis-à-vis constitutional provisions that say socio-economic rights are non-justiciable. While the Supreme Court has clarified that African Charter-rights are enforceable in Nigeria through court processes deploying rules of procedure of Nigerian courts (see *Ogugu v State* [1996] 6 NWLR (Pt 316) 1, 30-31 (Supreme Court of Nigeria)), it has equally not given much weight to African Charter rights. In *Abacha v Fawehinmi* [2000] 6 NWLR (Pt 660) 228 [Supreme Court of Nigeria], the court maintained that African Charter rights do not rise above the status of a constitutional norm. The court was willing to concede that the African Charter possesses 'a greater vigor and strength' than any other domestic statute. However, it was of the view that it ranked below the Constitution and thus conflicts between the Constitution and the African Charter must be resolved in favor of the Constitution.

[12] See my forthcoming paper in the African Journal of International and Comparative Law titled: "Constitutional Rights Norms as 'Guidelines and Impulses'? Towards an Account of Health Rights Normativity in the Global South" (2019).

[13] See *supra* note 11.

[14] See *supra* note 10.

[15] In terms of the scholarship, see for instance Alicia Ely Yamin & Siri Gloppen eds, *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Boston: Harvard University Press, 2011); Varun Gauri & Daniel M Brinks eds, *Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World* (Cambridge: Cambridge University Press, 2008).

that there are potentially four outcomes that can result from the litigation of the right to health – and two of these are not helpful for the fulfilment of the right. They include enabling the right, amplifying the right, impeding the right, and being ambivalent towards the right.[16]

I have suggested that courts enable the right, within the meaning of this taxonomy, when their decisions serve as a basis for the recognition of an enforceable right to health in the absence of adequate constitutional, policy and/or legislative guarantees of the right. Courts that can potentially act as enablers of the right to health require a favorable predisposition to judicial activism and the ability to withstand the inevitable criticisms that attend such predisposition. The value of the court that enables the right to health is best appreciated in political settings where other branches of government have taken a backseat in initiating and/or implementing policies and legislation that recognize and the protect the right. The Supreme Court of India is offered as an example of a court that has enabled the right to health. This conclusion is informed by the fact that the Supreme Court of India has gradually advanced the recognition of the right through a series of decisions that have moved the right from a position of non-justiciability[17] to one where it is now routinely cited among the fundamental rights protected under the *Indian Constitution.*[18]

I have also suggested that courts amplify the right to health, according to this taxonomy, when their decisions serve as a basis for strengthening and giving effect to existing constitutional and/or legislative guarantees of the right. The amplifying process requires courts to be actively involved in strengthening the enforcement regime of the right to health by balancing competing interests in society and establishing the best way to bring about the fulfilment of the right in the light of these competing interests. Ideally, this occurs in situations where there is no dispute as to the justiciability of the right to health and where the focus of the court is on how best to mediate competing demands on scarce state resources. This is not to suggest that the amplifying process cannot also occur in other settings. For instance, India's formal acceptance of the right to health – through health rights litigation, without constitutional or legislative guarantees of the right – has saddled the courts with the responsibility of balancing competing interests in strengthening its uptake in India. South Africa, on the other hand, is a prime example of where courts have amplified the right to health. This is because South Africa has done a lot in addressing policy, regulatory and

[16] See Uchechukwu Ngwaba, *A Right to Universal Health Coverage in Nigeria? A Transformative Proposal from a Comparative Perspective* (Doctoral Dissertation, Macquarie University, 2017) 223 [unpublished] [Ngwaba].
[17] See *Constitution of India,* art 37; Ngwaba, *Ibid* at 242-43.
[18] *Reddy v Revanma, [2007] SC 1753 AIR (Supreme Court of India).*

implementation gap claims.[19] This has gone a long way in strengthening the situation of the right to health in South Africa.[20]

Furthermore, according to this taxonomy, courts impede the right to health when their decisions do not take account of the best way to balance competing interests of other stakeholders in society. Admittedly, value judgments are involved in assessing whether an approach taken by a court in a particular case is the best way to resolve the dispute. However, because of the complexities involved in litigating claims based on the right to health, such value judgments inevitably arise as a consequence of the *means-ends* debate about the allocation of scarce resources to address public health needs. There is thus a pressing need for courts to avoid deontological modes of reasoning and valuation, under which the only considerations taken into account by the courts are those of the applicants before them, relevant laws and constitutional texts, and their own predispositions.[21] Courts ought rather to embrace aggregative/utilitarian logic where judicial decisions take into account infrastructural limitations, anticipate legislative and executive priorities, and engage other stakeholders in an ongoing dialogue on how best to respect, protect and fulfil the right to health.[22] Brazil is an example of a state where it is argued courts are impeding the right to health. Thousands of lawsuits are filed every year in Brazil by individuals – and to a lesser extent groups – claiming some kind of health good (medication, surgery, medical equipment, and even food and diapers) based on the right to health guaranteed in the *Constitution of Brazil.* Largely as a result of the expansive interpretation of the right to health adopted at all levels of the Brazilian judiciary, most of these lawsuits have been successful for claimants. This approach of the courts in Brazil is one that considers the right to be 'an individual entitlement to *any* health procedure, equipment, or product that a person can prove he/she needs, irrespective of its costs'.

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[19] *Biljoen v Minister of Correctional Services* [1997] 4 SA 441 (South Africa High Court) is an example of a policy gap claim which addressed a gap in policy on whether the constitutional right to adequate medical treatment extended to prisoners. The court held that it did; *Tau v GloxoSmithKline* Case No. 2002 Sep226 (Competition Commission) a case brought under the *Competition Act 1998* (South Africa) ss 49B(2)(b) and 8(a) exemplifies a regulatory gap claim. Although the case did not achieve final determination by the courts because it was withdrawn, the litigation process provided an impetus for the resolution of the policy issues surrounding the availability of generic ARV medicines to the public; and *Minister of Health and Welfare v Woodcarb Pty Ltd* [1996] 3 SA 155 (South Africa Provincial Division) illustrates an implementation gap claim. The action was brought pursuant to the *Atmospheric Pollution Act 1965* (South Africa) and the constitutional right to an environment not harmful to health. The Natal Provincial Division Court granted an interdict prohibiting respondents from continuing with the pollution activities. The decision gave impetus to the enforcement of an existing constitutional right and legislative policy on the environment.

[20] Ngwaba, *supra* note 16 at 243.

[21] See Varun Gauri & Daniel M. Brinks, "Introduction: The Elements of Legalization and the Triangular Shape of Social and Economic Rights" in Gauri & Brinks, *supra* note 15 at 5.

[22] *Ibid.*

This has given rise to an exponential growth in health rights litigation in Brazil. This development has stirred mixed feelings about the benefits (equity impact) of health rights litigation in Brazil. While there are no doubt positive impacts to be derived from this development, especially for health seeking members of the public, the more dominant perception (especially among health administrators) is that the judicialization of the right to health is an epidemic that needs to be curbed.[23] Although the Brazilian courts have been relatively effective in interpreting and enforcing the constitutional guarantees of the right to health and a plethora of legislative instruments protecting that right, they are yet to elevate a judicial policy where individualism does not frequently trump the interests of the collective. This has opened up the Brazilian courts to many criticisms[24] and left behind an unconvincing account of their efforts to promote health equity in Brazil. To be clear, I am not suggesting here that giving effect to individual claims on the right to health is wrong (as such a view will be contrary to the essence of *legal positions*). What is being argued is that individual claims on the right to health need to be balanced against the larger collective interest of ensuring equity in the health system. The South African case of *Soobramoney v Minister of Health KwaZulu-Natal*[25] is a salient illustration of how courts can weigh up competing interests to ensure that individual interests do not always trump the interest of the collective.

Finally, courts demonstrate ambivalence towards the right to health, under this taxonomy, when their decisions avoid firm commitments that protect the right. An ambivalent court may not directly declare that it will not enforce the right to health. On the other hand, its decisions will not demonstrate a commitment to clarifying what the right means and how it can be respected, protected and fulfilled. Courts inclined to ambivalence towards the right to health are usually aided first by constitutional provisions that declare economic and social rights to be non-justiciable, second by an absence of legislation that protects the right to health, and third by the unwillingness of other branches of government to take responsible actions to protect the right. The difficulty with the ambivalent court is that it does not declare outright that it will not protect the right to health. Instead it adopts the tenuous distinctions and all manner of exclusionary rules (including rules as

[23] See Octavio L Motta Ferraz, "The Right to health in the Courts of Brazil: Worsening Health Inequities?" (2009) 11:2 Health & Hum Rts 33.
[24] See Octavio L Motta Ferraz, "Brazil: Health Inequalities, Rights, and Courts: The Social Impact of the Judicialization of Health" in Yamin & Gloppen *supra* note 15 at 76-102.
[25] *Soobramoney v Minister of Health KwaZulu-Natal* [1998] 1 SA 765 (Constitutional Court).

to standing),[26] such that the right to health has no practical meaning as basis for demands to be made of state institutions to observe, respect and give effect to the right.[27] In extreme cases, the ambivalent court may refuse to act even when there are legitimate bases for it to do so, such as where a treaty that protects the right to health has been incorporated into the domestic system.[28] Nigeria is a prime example of where the courts have demonstrated ambivalence towards the right to health.[29] This is because despite the incorporation of the African Charter on Human and Peoples' Rights into Nigeria's domestic law,[30] the Supreme Court of Nigeria has quarantined that treaty by declaring that the incorporating statute stands on its own subordinate to the constitutional regime, which treats socio-economic rights as non-justiciable.[31]

What the foregoing discussion demonstrates is that claims based on the right to health are fraught with difficulties as to its meaning, content and how best to bring it to fruition. It is against this backdrop that the need to strengthen the framework of the right with legal positions arises. Section III examines the specific ways legal positions can help revitalize the framework of the right to health so that it can be converged with universal health coverage and in a way that resource-constrained nations will be able to achieve better health outcomes.

B. UNIVERSAL HEALTH COVERAGE

Universal health coverage involves a set of health goals adopted by member states of WHO in 2005 to be achieved by health systems around the world.[32] These goals call upon member states to secure a level of access to health-care for their population that is not catastrophic and impoverishing. Health spending is said to be "catastrophic" whenever it is 40% or more of the capacity to pay.[33] Three dimensions are captured by the goal of universal health coverage as clarified by the 2010 WHO World Report, namely: the health services that are needed, the number

[26] Chidi Anselm Odinkalu, "The Impact of Economic and Social Rights in Nigeria: An Assessment of the Legal Framework for Implementing Education and Health as Human Rights" in Gauri & Brinks eds, *supra* note 15 at 218.
[27] See *supra* note 11.
[28] *Ibid.*
[29] *Ibid.*
[30] See *African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act 1983* (Nigeria).
[31] *Abacha v Fawehinmi supra* note 11.
[32] World Health Assembly, *Sustainable Health Financing, Universal Coverage and Social Health Insurance,* Wha Res 58.33, 9th Plen Mtg, Doc A58/20 (25 May 2005). [World Health Assembly]
[33] Kei Kawabata, Ke Xu, & Guy Carrin, 'Preventing Improverishment through Protection against Catastrophic Health Expenditure', (2002) 80(8) Bulletin of the World Health Organization 612.

of people that need them, and the costs to whoever must pay – users and third party funders.[34]In proposing a blueprint for achieving better health outcomes, I argue that universal health coverage, on its own, is not a sufficiently precise target for the campaign for public health in resource-constrained nations such as Brazil, India, Nigeria and South Africa (hereafter the resource-constrained nations), as it reminds one of unresolved controversies about the meaning and content of the right to health in international law.[35] These controversies necessitated the clarification by the ICESCR that the right to health does not mean the 'right to be healthy', rather, it consists of the interrelated and essential elements of 'availability, accessibility, acceptability and quality'.[36]

Universal health coverage seeks greater access to health care and lower cost of health spending for everyone in every country of the world.[37] The right to health on the other hand calls upon states to invest more in their health systems so that everyone can achieve the highest attainable standard of health.[38] Both frameworks expect high income countries (like Australia, Canada and the United States) to assist lower income ones (like the resource-constrained nations) to achieve their respective public health targets through technical and other forms of assistance.[39] The difficulty, however, is that the goal of universal health coverage has not been clearly articulated to avoid the imprecision that characterized earlier goals such as achieving "the highest attainable standard of health"[40] and/or "health for all".[41]

There is much merit in the argument that the goals of universal health coverage can converge with those of the right to health. I agree with scholars who argue that the right to health can contribute a lot to universal health coverage by providing justification for why states should prioritize their healthcare needs in the midst of crippling and competing domestic demands for

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[34] World Health Organization, *The World Health Report: Health Systems Financing: The Path to Universal Coverage*, (Geneva: WHO Press, 2010) 2.
[35] See Part II(a) above where these issues have been treated; for further reading, see Callahan, *supra* note 4 at 77-87; Campos, *supra* note 5 at 251; Katharine G Young, "The Minimum Core of Economic and Social Rights: A Concept in Search of Content", (2008) 33 Yale J Int'l L 113.
[36] Committee on Economic Social and Cultural Rights, *supra* note 6 at para 8.
[37] World Health Organization, *The World Health Report: Health Systems Financing: The Path to Universal Coverage*, (Geneva: World Health Organization, 2010). [World Health Organization].
[38] Committee on Economic Social and Cultural Rights, *supra* note 6.
[39] World Health Organization, *supra* note 34; see also *International Covenant on Economic, Social and Cultural Rights supra* note 7 at art 2(1).
[40] *International Covenant on Economic, Social and Cultural Rights supra* note 7 at art 12.
[41] World Health Organization and United Nations Children's Fund, "Alma Ata 1978 Primary Health Care", online: <http://www.unicef.org/about/history/files/Alma_Ata_conference_1978_report.pdf>.

scarce resources.[42] The right to health can also justify why relatively well-off states such as Australia, Canada and the United States should assist less well-off states such as the resource-constrained nations achieve universal health coverage.[43] I am however not in agreement with the scholarship on the specification of objectives for universal health coverage without a clear emphasis on health outcomes.[44] Better health outcomes should be the main objective of universal health coverage because it is a more measurable and attainable goal than those framed in the current understanding of universal health coverage. In this regard, I define better health outcomes to include significant reductions in mortality rates and morbidity ratio, less communicable and non-communicable diseases, and improvements in the underlying determinants of health. In face "better health outcomes" is an incentive for international donor-countries like Australia, Canada and the United States to work with resource-constrained nations like those discussed in this paper to achieve the right level of technical and financial support.

A second area of my disagreement with the scholarship is the *locu*s where the discourse on the meaning and content of the right to health should take place. The literature appears to support the need to resolve this controversy at the international level, before countries can adopt these ideas in their domestic system through appropriate legislative and other measures.[45] I argue, however, that the resolution of this question should occur at the domestic level. Each country should, on the basis of its local circumstances, driven by domestic social activism, and inspired by international law specify what the right to health means for its population.[46] In developing these

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[42] Gorik Ooms et al., "Universal Health Coverage Anchored in the Right to Health", (2013) 91:2-2A Bulletin of the World Health Organization 1; Gorik Ooms et al., "Great Expectations for the World Health Organization: A Framework Convention on Global Health to Achieve Universal Health Coverage", (2014) 128 Pub Health 173; Richard Horton, "Offline: Who Cares About Human Rights Anyways", (2013) 382 The Lancet 1390.

[43] Lawrence O Gostin et al., "The Joint Action and Learning Initiative: Towards a Global Agreement on National and Global Responsibilities for Health", (2011) 8:5 PLoS Medicine 1.

[44] Ooms et al., "Universal Health Coverage Anchored in the Right to Health", *supra* note 42; Ooms et al., "Great Expectations for the World Health Organization: A Framework Convention on Global Health to Achieve Universal Health Coverage", *surpa* note 42.

[45] Committee on Economic Social and Cultural Rights, *supra* note 6; Lawrence O Gostin, 'The Human Right to Health: A Right to the "Highest Attainable Standard of Health"', (Hastings Center Report, 2001); Jennifer Prah Ruger, "'Towards a Theory of a Right to Health: Capability and Incompletely Theorized Agreements", (2006) 18(:2) Yale Law Journal of Law & the Humanities 273-326.

[46] In this article, the international treaty framework refers to '*Constitution of the World Health Organization* Preamble, 62 Stat. 2697, 14 UNTS 185 (22 July 1946); *Universal Declaration of Human Rights*, GA Res 217A (III), UN GAOR, 3rd Sess, 183rd Plen Mtg, UN Doc A/810 (10 December 1948) art 25; *International Covenant on Economic, Social and Cultural Rights*, *supra* note 7 at art 12; *Convention on the Elimination of All Forms of Discrimination against Women*, 18 December 1979, 1249 UNTS 13 (Entered into Force 3 September 1981) art 12; *Convention on the Rights of the Child*, 20 November 1989, 1577 UNTS 3 (Entered into Force 2 September 1990) art 24; *African (Banjul) Charter on Human and Peoples' Rights*, 27 June 1981, OAU Doc Cab/Leg/67/3 Rev. 5, 21 ILM 58 (Entered into

two arguments, I build on Robert Alexy's constitutional theory on *legal positions*.[47] I argue that legal positions, when used to strengthen the normative framework of the right to health and universal health coverage in the domestic system of resource-constrained nations, can likely lead to better health outcomes.

C. RESOURCE-CONSTRAINED NATIONS

The term "resource-constrained nations", as used in this paper, refers to countries the World Bank classifies as low-and-middle income in its classification of country income groups. Based on this classification, Brazil and South Africa are upper middle-income countries[48] while India and Nigeria are lower middle-income countries.[49] The focus on these countries is not to suggest that they are the most "resource-constrained" nations that could have been examined in this paper. On the contrary, by virtue of being middle income countries, these countries are in many ways well placed to achieve better health outcomes than other extremely resource-constrained nations that dot the landscape of the World. While this may be so, the framework developed by this paper does not depend on the degree of resource-constraint to be applicable. It may however require stronger levels of commitment by domestic and international actors for the framework to be applicable in extremely resourced-constrained nations.

III. THE PARADIGM OF LEGAL POSITIONS AND THE RIGHT TO HEALTH

In his work *A theory of constitutional rights* Alexy draws a distinction between a *norm* and a *position.*[50] According to Alexy, a norm expresses the rights an individual has in something.[51] Positions on the other hand, reflect the relationships created between rights holders, the subject

Force 21 October 1986) art 16; *American Declaration of the Rights and Duties of Man, (*Adopted by the Ninth International Conference of American States, Bogota, Colombia, 2 May 1948) *American Declaration of the Rights and Duties of Man, (*Adopted by the Ninth International Conference of American States, Bogota, Colombia, 2 May 1948) art XI; and *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights "Protocol of San Salvador",* 17 November 1988, 69 OASTS (Entered into Force 16 November 1999) art 10.

[47] Robert Alexy, *A Theory of Constitutional Rights*, trans. Julian Rivers (Oxford: Oxford University Press, 2002).

[48] ChartsBin Statistics Collector Team, "Country Income Groups (World Bank Classification)", online: http://chartsbin.com/view/2438.

[49] *Ibid*.

[50] Alexy, *supra* note 47 at 114.

[51] *Ibid.*

matter of rights, and the duty bearers who fulfill those rights.[52] A clear connection between these three elements is what Alexy suggests is required to have a well-grounded right to something. Using the example of a right to emergency medical treatment, assuming such a right is guaranteed by the constitution of a state, a good framing in accordance with legal positions may read thus: "*x* shall not be refused emergency medical treatment for any reason by a health care provider, health worker or health establishment". In this example, 'x' is the beneficiary of the right to emergency medical treatment; the subject matter of the right is emergency medical treatment; and the addressees of the right are health care providers, health workers, and health establishments. Alexy's framework suggests that this right is well framed because its subject matter contemplates the acts of the addressees.[53]

On this basis, it seems the logical coherence of legal positions depends on the presence of all three elements. Taking any of the elements out of the equation results is an incoherent normative statement. For instance, in the example given above, removing the addressees of the right to emergency medical treatment from that equation, will result to an incoherent normative statement without real value to the right-holder. For example, assuming the right were to be reframed thus, "*x shall not be refused emergency medical treatment for any reason*", this new version of the norm statement, in my view, will be incoherent because it fails to tell us who owes *x* the obligation of an emergency medical treatment. Thus *x*, as the right-holder, cannot really enforce the right against anyone, as no one has been addressed by the norm declaring that right.[54]

Alexy's framework also takes account of Hohfeld's theory of legal relations. Hohfeld's work in a two-part piece appearing in 1913 and 1917 respectively[55] has significantly influenced and promoted the modern debate about legal relations.[56] The heart of Hohfeld's theory is his thesis about the logical connections between jural relations. According to Hohfeld, there are eight

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[52] *Ibid*.
[53] *Ibid* at 121.
[54] Alexy asserts that even with such norms that appear to only have "a two-point relation between a right-holder and an object, which in this case is a certain state of affairs for the right holder…[s]uch a right would correspond to what in classic terminology is called a "*ius in rem*" and can be contrasted with a "*ius in personam".* There can be no doubt that for reasons of simplicity one can speak of rights in the sense of relations between a legal subject and an object. Talk of such relations is nevertheless nothing more than an abbreviation for a complex of rights to something, liberties and/or powers.' See Alexy, *supra* note 47 at 121.
[55] Wesley Newcomb Hohfeld, "Some Fundamental Legal Conceptions as Applied in Judicial Reasoning" (1913) 23 Yale LJ 26; Wesley Newcomb Hohfeld, "Fundamental Legal Conceptions as Applied in Judicial Reasoning" (1917) 26 Yale LJ 710-770.
[56] Alexy, *supra* note 47 at 132.

'strictly legal relations…sui generis'.[57] He calls these 'right', 'duty', 'no-right', 'privilege', 'power' 'liability', 'disability', and 'immunity'.[58] The first four concern the field of rights to something (and are thus relevant to this paper), the last four related to the field of power.[59] While 'right', 'duty', 'no-right', and 'privilege' stand in Hohfeld's system for legal relations between two legal subjects, Alexy's legal positions considers rights as three-point relations between a right-holder, an addressee, and a subject-matter. Alexy notes however that this does not make Hohfeld's scheme inapplicable. Alexy suggests Hohfeld's scheme can be considered as an abbreviation of the three-point legal relations captured by legal positions.[60]

Alexy's theory of legal positions offers interesting insights when considering the constitutional formulation of the right to health in the resource-constrained nations. Nigeria and India stand as examples of countries with weak legal positions on the right to health, while Brazil and South Africa stand as examples of countries with strong legal positions on the right to health. For both Nigeria and India, the constitutional guarantee of the right to health, whilst conforming to the tripartite framework of legal positions suggested by Alexy (i.e. beneficiaries, subject-matter and addressee), suffers from derogatory provisions that weaken the obligations of the addressee(s) of the right, and in the process disemboweling this framework. For instance, s 17(3)(d) of the Nigerian Constitution (which is part of the Fundamental Objectives and Directive Principles of State Policy in Chapter II of the Constitution) in providing the main guarantee of the right to health states that "the state shall direct its policy towards ensuring that there are adequate medical and health facilities for all persons."

At first glance, this is a strongly worded provision that accords with a strengthened legal position on the right to health. However, when read in the light of s 6(6)(c) of the Constitution which restricts the courts from adjudicating violations of the rights contained in Chapter II of the Constitution, it becomes clear that the constitutional framing of the right did not properly contemplate the act of the addressee. In the same vein, the Constitution of India provides for the right to health in arts 39(e) and (f) and 47 in terms that accord with the tripartite framework of legal positions. However, like the Nigerian context, the Indian Constitution derogates from these rights (which are contained in Part IV of the Constitution) by providing in art 37 that the rights

[57] Hohfeld, "Some Fundamental Legal Conceptions", *supra* note 55 at 36
[58] *Ibid*.
[59] Alexy, *supra* note 47 at 132.
[60] *Ibid* at 133.

contained in Part IV are non-justiciable. On this basis therefore, the framing of the right to health in the Indian Constitution, just like in the Nigerian Constitution, does not adequately contemplate the act of the addressee of the right (that is the state).

Brazil and South Africa, in contrast to Nigeria and India, provide constitutional guarantees of the right to health that accord with the tripartite framework of legal positions and do not derogate from the right so provided.[61] Both constitutions offer better conditions for the uptake and implementation of the right to health. They also do not draw a direct causal link between the constitutional guarantees of the right to health and the prospects for better health outcomes in these countries. However, it seems that strongly framed constitutional guarantees of the right to health that accord with the tripartite framework of legal positions (without any form of derogation from the right), at the very least, provide conditions for the right to health to thrive. They also are more likely to result in better health outcomes by securing underlying determinants of health. [62]

At the international level, the framing of the right to health in art 12(1) of the International Covenant on Economic, Social and Cultural Rights, when viewed through the lens of legal positions, seems to be weak as it merely enjoins State Parties to recognize the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health". A right of recognition, it could be argued, is not nearly strong enough to compel addressees of a right to take active measures to guarantee that right. Besides, a similar problem occurs with the framing of universal health coverage by WHO due to lack of clarity in the expression of its goals.[63]

IV. UNIVERSAL HEALTH COVERAGE: PROBLEMS, PROMISE, STRENGTHENING AND CONVERGENCE

How does the current framing of universal health coverage make it susceptible to the shortcomings of previous frameworks such as the "right to health" and "health for all"? What is the promise for strengthening health systems in resource-constrained nations through bolstering universal health

[61] For Brazil, art 196 of the *Constitution* provides that "health is a right of all and the duty of the state to guarantee by means of social and economic policies aimed at reducing the risk of illness and other hazards and at the universal and equal access to actions and services for its promotion, protection and recovery"; For South Africa, s 27(1)(a) of the Constitution states that 'everyone has the right to have access to health care services, including reproductive health care'.

[62] In another paper I deal with this issue more clearly. See my forthcoming paper in the African Journal of International and Comparative Law titled: "Constitutional Rights Norms as 'Guidelines and Impulses'? Towards an Account of Health Rights Normativity in the Global South" (2019).

[63] World Health Assembly, *supra* note 32.

coverage with normative recognition of the right to health? Can the clarification of targets for universal health coverage, and convergence with a re-invigorated paradigm of the right to health, using the concept of legal positions, better situate the health systems of the resource-constrained nations to achieve better health outcomes? These are the questions that are answered in this section of the paper.

A. THE PROBLEMS WITH THE FRAMING OF UNIVERSAL HEALTH COVERAGE

The first problem with universal health coverage is that it is framed with an excessive focus on clinical outcomes to the exclusion of underlying determinants of health.[64] The non-engagement with underlying determinants of health reflects the fact that the right to health has not adequately informed the framework of universal health coverage.[65] In fact, the preparatory work leading to the adoption of the SDGs seems to confirm this view. As Brolan and others observe, in respect of the work done on the SDGs, the right to health was "everywhere but not specifically somewhere".[66] A pointer to the focus on clinical outcomes is SDG 3, the health goal providing for universal health coverage. SDG 3.8 says its target is to "[a]chieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all."[67] The focus on clinical outcomes by SDG 3.8 dismantles advances recorded in mainstreaming human rights language in international public health discourse.[68] SDG 3.8 fails to account for the now settled understanding that health outcomes are not determined solely by medical factors such as health care services, drugs and vaccines, but by a combination of health and non-health factors.[69] Similarly, SDG 3.8 plays into the hands of states, particularly the resource-constrained ones, that may not be inclined towards human rights

[64] For scholarly support of this thinking, see Lisa Forman et al, "What Do Core Obligations Under the Right to Health Bring to Universal Health Coverage?", (2016) 182 Health & Hum Rts J 23.
[65] See Lisa Forma, Gorik Ooms, Claire E. Brolan, "Rights Language in the Sustainable Development Agenda: Has Right to Health Discourse and Norms Shaped Health Goals?", (2015) 4:12 Int'l Health Pol'y & Mgmt 799.
[66] See Claire E Brolan, Peter S. Hill & Gorik Ooms, "Everywhere but not Specifically Somewhere": A Qualitative Study on Why the Right to Health is not Explicit in the Post-2015 Negotiations', (2015) 15:22 BMC Int'l Health & Hum Rts 1.
[67] World Health Organization, *supra* note 1.
[68] Benjamin Mason Meir, "Global Health Governance and the Contentious Politics of Human Rights: Mainstreaming the Right to Health for Public Health Advancement", (2010) 46:1Stan J Int'l L 1
[69] Committee on Economic Social and Cultural Rights, *supra* note 6.

or equity in their health systems. SDG 3.8 also potentially lowers the bar for resource-constrained states, with respect to the extent of their responsibilities for health.[70]

The second problem with universal health coverage is its lack of clarity on targets. This is observable from the changing definition of its subject-matter. In 2005, it emerged on the global health agenda with a primary focus on health financing and insurance. In its most recent iteration in the SDGs, the focus appears to have shifted to health financing and clinical outcomes. The 2005 World Health Assembly resolution introducing universal health coverage defined it as "access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access."[71] The focus on health financing was further reinforced by the appeal to states "to ensure that health-financing systems include a method for prepayment of financial contributions for health care, with a view to sharing risk among the population and avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking care."[72]

The 2010 *World Health Report* also did little to clarify the content of the services brought under universal health coverage. The report instead identified three dimensions to be covered, based on a cube designed by Reinhard Busse et al,[73] namely: the range of health services available, the proportion of costs of services covered, and the proportion of the population covered.[74] In 2012, the UN General Assembly offered a fuller multidimensional definition of universal health coverage that "affirmed in explicit and detailed terms everyone's right to health and recognized the responsibility of governments to urgently and significantly scale up efforts towards access to affordable and quality health-care services"[75]. The resolution required that:

> [a]ll people have access, without discrimination, to nationally determined sets of the needed promotive, curative and rehabilitative basic health services and essential, safe, affordable, effective and quality medicines, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor, vulnerable and marginalized segments of the population.[76]

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[70] In this respect, Lisa Forman et al, note the "danger of universal health coverage reducing health care downwards, without specifying a floor for essential health care itself". See Forman et al, *supra* note 65 at 31.
[71] World Health Assembly, *supra* note 32 at para. 2.
[72] *Ibid.*
[73] See Reinhard Busse, Jonas Schreyögg, and Christian Gericke, *Analyzing Changes in Health Financing Arrangements in High-Income Countries: A Comprehensive Framework Approach* (Washington DC: The International Bank for Reconstruction and Development / The World Bank 2007)
[74] See World Health Organization, *supra* note 40 at xvi.
[75] See Forman et al, *supra* note 65 at 25.
[76] UN General Assembly, Global Health and Foreign Policy, UN Doc. A/67/L.36 (2012) para. 10.

The lack of consistency and clarity in the targets of universal health coverage is reminiscent of the experiences with the iteration of the *right to health* in international law, and the unfulfilled aspirations of the Alma Ata Declaration and its campaign for *health for all*. Without a clear specification of targets, the global campaign for universal health coverage is likely to go the way of those of the human right to health and health for all. As such, any attempt to specify the targets of universal health coverage that fails to inculcate underlying determinants of health into its framework would make it "susceptible to exploitation, particularly within the market driven global environment",[77] and this will not augur well for the health systems of resource-constrained nations.

B. THE PROMISE OF UNIVERSAL HEALTH COVERAGE

Despite its challenges, universal health coverage holds a lot of promise for health systems strengthening, particularly in resource-constrained nations. Perhaps its greatest contribution is the specific focus it brings to addressing situations of lack of access to health care, either by reason of the unavailability of health goods and services, or the unavailability of financial resources to pay for health goods and services. There are certainly other areas where universal health coverage is likely to make positive impact. However, I will restrict my focus to these two areas.

(i) Refocusing the discourse on availability of health goods and services

Lack of access to health occasioned by unavailability of health goods and services is by many accounts one of the most serious challenges facing resource-constrained nations. Many factors account for this problem. I loosely categorize them as institutional, geographical, or human resource factors.

By institutional factors, I have in mind policies of state institutions that hinder specific or whole segments of the population from accessing health. In India for instance, during its first universal periodic review (UPR) cycle in 2008,[78] a question that Germany posed was what India

[77] See Forman et al, *supra* note 65 at 31; People's Health Movement et al, *Global Health Watch 4: An Alternative World Health Report* (London: Zed Books Ltd, 2014) 82.

[78] The Universal Periodic Review (UPR) is a unique process which involves a review of the human rights records of all UN Member States. The UPR is a State-driven process, under the auspices of the Human Rights Council, which provides the opportunity for each State to declare what actions they have taken to improve the human rights situations in their countries and to fulfil their human rights obligations. As one of the main features of the Council, the UPR is designed to ensure equal treatment for every country when their human rights situations are assessed. The ultimate aim of this mechanism is to improve the human rights situation in all countries and address human rights violations wherever they occur. Currently, no other universal mechanism of this kind exists. See United Nations Human Rights Council, "Universal Periodic Review" online: <https://www.ohchr.org/en/hrbodies/upr/pages/uprmain.aspx>.

was doing to ensure access to medical services for the *Dalits* (also known as the untouchables) and other caste groups.[79] For Brazil, the institutional factor flagged at its first UPR was the criminalization of abortion giving rise to abortion in unsafe conditions.[80] For Nigeria, it was barriers to obtaining quality maternal care created by user fees.[81] In South Africa's, the challenges flagged were poor accountability and oversight mechanisms in the health system and their impacts on increasing maternal deaths.[82] The framework of universal health coverage, with its emphasis on the availability of health goods and services, is likely to bring new urgency to these issues and many others in the resource-constrained nations.

Geographical factors such as where one lives tend to determine one's ability to access healthcare. Thus, people who reside in urban areas are more likely to have access to the best health goods and services than people who reside in rural areas. However, the gap in health care as a result of geographical factors are more pronounced in resource-constrained nations. This is therefore an area where the global campaign for universal health coverage is likely to benefit the health systems of resource-constrained nations.

Regarding human resource factors, every year, thousands of health workers migrate from countries of the global South,[83] many of which are resource-constrained,[84] to countries of the global north, many of which fall within the category of 'resource-adequate' as used in this paper. Such health workers leave behind health systems in resource-constrained nations starved of

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[79] See Office of the High Commissioner for Human Rights, *Advance Questions to India* online: <lib.ohchr.org/HRBodies/UPR/Documents/Session1/IN/QUESTIONSINDIA.pdf>.

[80] Human Rights Council, *Summary Prepared by the Office of the High Commissioner for Human Rights, in Accordance with Paragraphs 15(c) of the Annex to Human Rights Council Resolution 5/1: Brazil,* 1st sess, UN Doc A/HRC/WG.6/1/BRA/3 (6 March 2008) para. 40.

[81] Human Rights Council, *Summary Prepared by the Office of the High Commissioner for Human Rights in Accordance with Paragraph 15(c) of the Annex to the Human Rights Council Resolution 5/1: Nigeria,* 4th sess, UN Doc A/HRC/WG.6/4/NGA/3 (27 November 2008) paras. 50-55.

[82] Human Rights Council, *Summary Prepared by the Office of the High Commissioner for Human Rights in Accordance with Paragraph 5 of the Annex to Human Rights Council Resolution 16/21: South Africa,* 13th sess, UN Doc A/HRC/WG.6/13/ZAF/3 (12 March 2012) para. 66.

[83] The North/South dichotomy used in this work draws from TWAILIAN sensibilities (TWAIL is the scholarly perspective identified as "Third World Approaches to International Law". TWAILIAN discourse maps the geography of the south not in terms of any specific location, but in the way international law impacts "the governed, no matter where they are spatially located". See Luis Eslava & Sundhya Pahuja, "Beyond the (Post)Colonial: TWAIL and the Everyday Life of International Law", (2012) 45:2 L & Pol Afr Asia & Latin Am 195, 197; see also James T Gathii, 'TWAIL: A Brief History of Its Origins, Its Decentralized Network, and a Tentative Bibliography', (2011) 3 Trade L & Dev 26; and Obiora Chinedu Okafor, 'Critical Third World Approaches to International Law (TWAIL): Theory, Methodology, or Both?', (2008) 10 Int'l Community L Rev 371.

[84] Brazil, India, Nigeria and South Africa, to varying degrees, are plagued by this problem.

essential health workforce and highly skilled health workers.[85] In resource-adequate nations, on the other hand, this phenomenon appears to be creating an oversupply of health workers. Yet availability of health workforce is vital to the functioning of health systems. By drawing attention to the need for global action in respect of the availability of health goods and services, universal health coverage stands to make an important contribution to health systems strengthening in resource-constrained nations.

(ii) *Addressing the issue of financing for health*

The resource-constrained nations, with the exception of South Africa, are to varying degrees plagued by high out-of-pocket expenditure for health goods and services.[86] This raises the specter of catastrophic health spending. Universal health coverage directly tackles this issue by canvassing for "a method for prepayment of financial contributions for health care, with a view to sharing risk among the population".[87] This is another area where the health systems of the resource-constrained nations will likely be strengthened by universal health coverage.

C. IMPERATIVES FOR STRENGTHENING UNIVERSAL HEALTH COVERAGE

The imperatives for strengthening universal health coverage is based on the discussion on the problems facing that framework due to its excessive focus on clinical outcomes, and lack of clarity as to its targets. As previously indicated, there is much scholarly support for including underlying determinants of health in the framework work of universal health coverage.[88] From all indications, such a measure is likely to gain the support of human rights institutions already working to mainstream the right to health in global health praxis. It is a difficult position to defend, sticking to a clinical or financial view of the health system and yet expecting it to be able to meet all the challenges confronting resource-constrained nations. It is for this reason that this paper has argued that underlying determinants need to feature in the framework of universal health coverage.

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[85] For a general reading on this see Joseph J Schatz, "Francis Omasawa: Tackling the Shortage of Health Workers", (2008) 371 The Lancet 643; Fitzhugh Mullan, "The Metrics of the Physician Brain Drain", (2005) 353: 17 New England J Med 1810; Lincoln C Chen & Jo Ivey Boufford, "Fatal Flows – Doctors on the Move", (2005) 353: 17 New England J Med 1850; and Esi E Ansah, 'Theorizing Brain Drain', (2002) 30(1) African Issues 21.

[86] This view is reinforced by reports of WHO's global health observatory on health financing. See World Health Organization, "Global Health Observatory (GHO) Data: Health Financing" online: <https://www.who.int/gho/health_financing/en/>.

[87] World Health Assembly, *supra* note 32.

[88] Ooms et al., "Universal Health Coverage Anchored in the Right to Health", *supra* note 42; Ooms et al., "Great Expectations for the World Health Organization: A Framework Convention on Global Health to Achieve Universal Health Coverage", *surpa* note 42.

In order to overcome the imprecision of the current framework, and the potential pitfalls arising from such imprecision, also it is argued that the target of universal health coverage should be better health outcomes – not merely strengthening the delivery of care and the system of health financing. What is 'better' in terms of health outcomes is relative to existing conditions that offer a basis for comparison. Therefore, I point to the most pressing areas where poor health outcomes are being experienced in the resource-constrained nations and argue that better health outcomes should seek to bring about significant improvements in these areas. By holding to this view, I invariably disagree with the *universalistic paradigm* for universal health coverage canvassed by Lisa Forman et al.[89]

D. THE CASE FOR CONVERGING UNIVERSAL HEALTH COVERAGE WITH THE RIGHT TO HEALTH

The case for converging universal health coverage with the right to health has been advanced by several scholars. Gorik Ooms et al, who prominently canvass this view (in the context of the health-related Millenium Development Goals (MDGs)), argue that "universal health anchored in the right to health, while building on efforts to meet the present health-related MDGs, would raise the bar for improving health care overall".[90] I believe this view still holds true for the SDGs. However, it is unclear if the current framework of the right to health in international law is well-grounded to provide the much needed bolstering to universal health coverage. It is possible that engagement with Alexy's paradigm of legal positions to strengthen the right to health is the most promising way out of this quandary for resource-constrained nations.

By concieving the right to health as a set of legal positions to universal health coverage, we are able to overcome the paralysing debate about the meaning and content of the right to health that has led to the dissipation of so much energy at the international level, without meaningful consensus or progress for global health. Legal postions can clarify the connection between the beneficiaries, subject-matter and addressees of the right to health. It can place clearly articulated duties on the doorsteps of state organs, and empower beneficiaries of the right to health to seek the fulfilment of that right through activism and recourse to the judicial process. This can benefit universal health coverage as an opportunity to frame the subject-matter of the right to health as

[89] See Forman et al, *supra* note 65 at 25.
[90] Gorik Ooms et al., "Universal Health Coverage Anchored in the Right to Health" *supra* note 42 at 2.

universal health coverage that should lead to better health outcomes. Thus, the duty of state organs does not stop at providing access to health goods and services; it also extends to ensuring that the underlying conditions required to bring about improvements in health outcomes are also addressed.

Legal positions can also create a *radiating effect* in resource-constrained nations. The "radiating effect" theory owes to the work of the Federal Constitutional Court of Germany. Alexy cites that court in developing this theory as follows:

> According to the long-standing case-law of the Federal Constitutional Court, constitutional rights norms do not simply contain defensive rights of the individual against the state, but at the same time they embody an objective order of values, which applies to all areas of law as a basic constitutional decision, and which provides guidelines and impulses for the legislature, administration and judiciary.[91]

The main benefit of the radiating effect theory for this paper lies in the idea that constitutional rights norms framing the right to health as legal positions to universal health coverage can provide guidelines and impulses for the legislature, executive and judiciary. It can also potentially empower domestic social actors with the required tools for advancing protections of the right to health and the uptake of universal health coverage in the domestic system of the resource-constrained nations.

V. CONCLUSION

In this paper, I have argued that if the right to health, understood as a set of legal positions to universal health coverage, is implemented in resource-constrained nations then better health outcomes are likely to result. In developing this framework, I have proceeded on the assumption that the current framework of universal health coverage, while offering a great deal of promise to health systems around the world, particularly in resource-constrained nations, nonetheless faces a number of serious shortcomings. The most significant of these shortcomings is the lack of clarity as to its targets, and the non-inclusion of underlying determinants of health as part of its subject-matter. I have argued that these shortcomings would potentially undermine its chances of success unless something is done. In walking around these challenges to bring about a strengthened framework of universal health coverage, I have argued for the convergence of universal health

[91] Alexy, *supra* note 47 at 352.

coverage with a revitalized framework of the right to health. The revitalization of the right to health, I have suggested, is through recasting the right to health as legal positions so as to properly clarify the nature of the obligations which claims about the right to health implicate. In the final analysis, I suggest that it is for each state to develop a constitutional paradigm of the right to health as legal positions that will enable it to tackle its most pressing health needs to bring about better health outcomes.