



Making Sense of Right to Health, UHC and SDGs

Submission from United Nations Major Group for Children and Youth (MGCY)

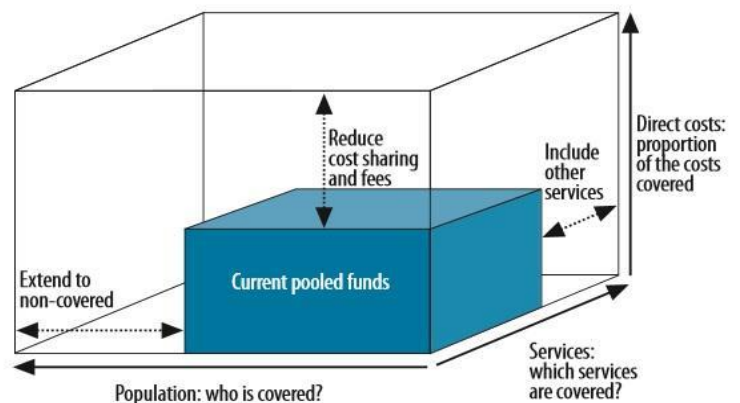
For United Nations High Commissioner for Human Rights

Part 1 : Background

This is a submission in response to the Human Rights Council resolution titled “The right of everyone to the enjoyment of the highest attainable standard of physical and mental health in the implementation of the 2030 Agenda for Sustainable Development” (A/HRC/35/L.18/Rev.1). In particular : "13. Requests the United Nations High Commissioner for Human Rights to prepare a report which presents contributions of the right to health framework to the effective implementation and achievement of the health-related Sustainable Development Goals, identifying best practices, challenges and obstacles thereto, and to submit it to the Human Rights Council at its thirty-eighth session;"

Part 2 : Summary

The right to health framework, in particular the discussion on core obligations of states, helps shape Universal Health Coverage (UHC) [1]. This submission considers how right to health framework can advance the three dimensions of moving towards universal coverage, providing good practices, and emphasising critical challenges and bottlenecks. We caution against a limited interpretation of UHC; recognising health is a much broader concept that spread through sustainable development goals (SDGs), we further elaborate on the need to address social determinants of health and equity. Finally, we describe UN MGCY itself as an example of participatory approach that can ensure right to health is entailed in SDGs.



Part 3 : Advancing the 3 dimensions of UHC / UHC Cube [2] by adopting a right to health approach

3.1 : Reducing cost sharing and fees

- Underuse of health services are multi-layered: it is a result of inadequate access, health system failures, clinicians being short-staffed, unaware or unskilled, and patients declining them [3]. While much discussion has been put on financing such as insurance coverage to reduce out-of-pocket

payment, **we argue that there are fundamental problems brought by high price of pharmaceutical products, as it is a major bottleneck for health systems and has increasingly been recognised as a global problem** [4].

- Access to affordable medicine is a politically sensitive issue that is often undermined by extensive pharmaceutical industry influence. The lack of accountability have led to it being neglected in the MDGs [5].
- It is important for governments to take proactive actions and exercise their rights to drive prices down.
- **Case : Malaysia being the first country in the world to issue a government-use license or a compulsory license for direct acting anti-virals (DAA) for hepatitis C**

In 2015, WHO added several high-priced new medicines—for the treatment of hepatitis C, tuberculosis, and cancers—to the Model List of Essential Medicines [6], reflecting the importance of these products to health systems' ability to meet population needs. However, the inclusion alone does not solve the affordability issue. It has been estimated, for example, that treating all eligible patients in the USA with DAAs would require an additional US\$65 billion over the course of 5 years. In Malaysia, hepatitis C virus infection prevalence is estimated at 2.5% of people aged 15–64 years, mostly among men [7]. However, sofosbuvir remains unaffordable for patients and the government alike, with a price set at about \$87 430 for a 24-week course, while its production is estimated to cost merely between \$68 and \$136 for a 12-week treatment course [8]. As it is a middle-income country, Malaysia usually did not receive special pricing for drugs by pharmaceutical companies. In September 2017, the Malaysian government issued government-use licences to bring in generics of hepatitis C medicine sofosbuvir, bring hope to affordable treatment for up to 400,000 hepatitis C patients in the country [9]. The move has been praised by civil society and NGO [10] [11].

- **Case : Colombia decreased the price of cancer drug Glivec despite external pressure**

Imatinib, marketed by Novartis as Gleevec, is used to treat leukemia. The drug costs up to \$15,161 USD per year — nearly double the gross national income per capita in Colombia. Meanwhile, the generic price for imatinib is as low as \$803 per year in India. A government technical committee recommended that compulsory license on imatinib it is in the public interest for Columbia to declare a compulsory license, a legal procedure that allows a government or a judge to authorize the non-voluntary use of a patented invention. In April 2016, Health Minister of Columbia opened negotiations with Novartis on a new price for imatinib. The effort was confronted by Novartis itself,

and even foreign pressure from the US. The political leadership of the Colombian government, together with support from World Health Organization and civil society, finally brought a 44% price reduction of Glivec in December 2016. [12] [13]

- **Case : CellScope - social responsibility licensing by university enables access**

CellScope is a microscope that attaches to a conventional cell phone developed in UC Berkeley. The technology enables health workers to send digital images of blood or tissue samples, removing the need for field-based laboratories. It accelerates disease diagnosis and allow epidemic tracking in countries lacking health infrastructures. CellScope offers free licenses in developing countries [14]. Public sector research institutions, such as universities and nonprofit research institutes, play a significant role in medical innovation. Such institutions have been estimated to have contributed to the discovery of as many as 21% of new drugs developed recently in the United States [15]. UC Berkeley's Socially Responsible IP Management and Licensing Program ("SRLP") program [16] is an example for universities to review their technology transfer policy to make sure the end product of their innovation does not fall out of reach by the people who need it most. Such effort should be amplified by a right to health perspective.

3.2 : Extending to non-covered

Migrants and refugees have fallen victim to either restrictive or ambiguous language

- Right to health, with its universal scope and principle of non-discrimination, has the potential to demand non-nationals' access to affordable health systems. **However, human rights treaties are sending mixed signals at both the international and regional levels**, as for example they may explicitly restrict migrant workers' right to health to emergency care only [17].
- There is evidence to suggest that **providing access to regular preventive healthcare for migrants would be cost-saving for healthcare systems**. For example, undocumented migrant women are at greater risk in pregnancy and have increased rates of maternal and perinatal mortality compared with the rest of the population (ref); the cost of providing emergency treatment to migrant women excluded from regular antenatal care far outweighs the cost of providing that care for free [18].
- **Migrants and refugees suffering from NCDs are more vulnerable** to the stresses of migration and the harsh conditions on migration routes, and suffer from a lack of regular access to suitable health care [19]. People living in emergency situations have 2 to 3 times higher risk of exacerbating pre-existing conditions or suffering acute complications [20].

LGBTQ community and their health is barely visible in the right to health

- Although some human right treaties (UDHR, art. 2; ICESCR, art. 2(2). ICCPR, art. 2(1)) prohibit discrimination “of any kind” or based on “other status”, **there is lack of concrete language that addresses the disparity of access of healthcare and unmet health needs of the LGBTQ community.** World Health Organization itself has faced resistance in leading all member states to address the issue, as there is currently only one PAHO resolution passed regarding violence and discrimination against LGBT. **Another challenge is health professionals' general lack of skills to understand and address the specific problems of this group** [21].

Poorest of the poor are suffering from lack of innovation for neglected diseases

- Although there are efforts to expand coverage to protect the poor, **the unavailable or limited treatment options for neglected diseases still place the poorest of the poor in a vicious circle of poverty and ill-health.** Among the 850 new therapeutic products approved between 2000 and 2011, only 4% were indicated for neglected diseases, even though these diseases account for 11% of the global disease burden [22].
- **Case : Drugs for Neglected Diseases initiative (DNDi) brings better treatments for neglected patients**

DnDi is a collaborative, patients' needs-driven, non-profit drug R&D organization. Its aim is to exercise a model in which research priorities ignore questions of profitability, and the price of medicines is “delinked” from research costs, which are instead shouldered by public financing or philanthropy. Set up by Doctors Without Borders, it has delivered 7 new patent-free, low-cost treatments, and has many more currently in pipeline [23] [24]. DnDi is recently partnering with pharmaceutical company Sanofi in developing novel treatments for Sleeping Sickness that have much less side effect and are orally available [25].

3.3 : Including other services

- All health systems have limited budget. Meanwhile, new medicines and technologies arise rapidly. **However, not all of them are cost-effective or addressing real social needs. There is also a shared misconception among the public that all new medicines are therapeutic innovations and bring better health outcomes.** In fact, take Europe as example, only a minority (around one quarter) of products approved by the European Medicines Agency (EMA) between 1995 to 2004 were categorised as innovative [26] [27].

- Health Technology Assessment (HTA) has been gaining attention in recent years for being a comprehensive means of decision-making on what services need to be prioritised. The concept of right to health should be carefully incorporated into its methodology.
- **Case : The Health Intervention and Technology Assessment Program (HITAP) of Thailand brings evidence and wisdom in decision-making**

HITAP was established by the Ministry of Public Health in Thailand to generate evidence to inform decision-making about which medicines and health technologies would be covered by the public health system. It also goes beyond consideration of the existing price of a product in the local market, and leads to the activation of price interventions aimed at ensuring the affordability of essential medicines.

Part 4 : Beyond UHC - the need to address social determinants of health and equity

- Despite the broad definition of including preventative care in UHC, many global health problems are linked to poverty and inequity. Health is therefore not achieved by healthcare alone [28] **Countries that address social and economic determinants of health can also demonstrate the best health outcomes** [29].
- The UHC Cube is reductive in a way that it only shows a country's coverage situation *in terms of national averages*. As a result, **it does not present or call attention to significant disparities in coverage across population groups**, which are characteristic of most low- and middle-income countries [30]
- Moreover, there has been debate on how UHC brings up the debate of private sector involvement [31]. It was suggested that states should conduct **human rights impact assessments to assess the consequences of privatization prior to its introduction** [32]

Part 5 : Commitment of MGCY and the role of the next generation

- We echo the resolution titled “Youth and Human Rights” (A/HRC/35/L.22), in particular, that *the full enjoyment of human rights and fundamental freedoms by young people empowers them to contribute as active members of society to the political, civil, economic, social, and cultural development of their countries*.
- We further elaborate that young people, with highest attainable standard of health, quality education and job opportunities, reinforce their role in advancing the right to health agenda for the whole of society.

- **The notion of how right to health framework contributes to SDGs should be brought into discussion among the next generation. Special focus should be put on stimulating future health professionals on fulfilling their moral obligation to protect the right to health of their patients and society as a whole.**
- **Case : The United Nations Major Group for Children and Youth (MGCY) as a platform for capacity building and participation**

The UNMGCY is the official space for young people to contribute in UN processes. Mandated by Agenda 21 and over a dozen other UN resolutions, it is one of nine Major Groups and other Stakeholders (MGoS) which constitute the stakeholder engagement mechanisms across the UN system. The UN MGCY is a space comprised of individuals under 30, youth-led and youth-serving organisations, and child-focused agencies [33]. Such a mechanism has the potential in linking high-level dialogues with grassroots actions, as well as conveying coherent messages among various health professional student groups.

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