1 Access to services and the right to health

RECOMMENDATION 1

To achieve universal access to services and protect the health and related rights of women, children and adolescents, governments should regulate private as well as public sector providers. Parliaments should strengthen legislation and ensure oversight for its enforcement. The UHC 2030 Partnership should drive political leadership at the highest level to address private sector transparency and accountability.

As licensed operators, private sector service providers must be subject to the same standards and regulations as public providers. Emphasis should be placed on ensuring that the health system as a whole offers equitable access to essential goods and services for women, children, adolescents and all those living in poverty and exclusion, including protection from catastrophic expenditures and impoverishment. Governments should establish clear standards of minimum financial coverage, mandated by legislation; compliance with these standards should be enforced through monitoring and oversight of public and private providers, including private health insurance companies. Due attention must be placed on addressing NCDs and mental health conditions, as well as on adolescents and people living with HIV and disabilities, among other marginalized communities.

To transform mindsets and overcome resistance and mutual distrust among ministry of health officials, private sector and civil society actors, governments should establish multi-stakeholder platforms for planning, implementation and monitoring. These can build bridges of mutual understanding for constructive accountability processes. Resource-poor countries will need support from the international community to overcome gaps in regulatory capacities.

1.1. Ministries of health should integrate for-profit providers into national health governance systems by developing private sector stewardship and accountability strategies.

KEY MEASURES

Require private sector providers and facilities to register and report to the ministry of health's management information systems; include them in system-wide performance monitoring and review processes; and harmonize quality of care standards across private facilities. *The purpose is to ensure that all services and health education comply with national policies and clinical protocols. This extends to private providers of immunization coverage. Particular attention should be paid to monitoring compliance in delivery of evidence-based sexuality education and sexual and reproductive health services.*

Ensure that both public and private health providers comply with international human rights obligations for the protection of patients' rights, and establish effective complaint and redress mechanisms. *Governments, as well as private providers, should ensure that the public is made aware of patients' rights and the grievance mechanisms available. The Government of Mexico, for example, has established a call-in system (CALIDATEL) that receives complaints covering both public and private providers; an arbitration mechanism has also been set up to resolve disputes over quality and costs. Human rights violations, including those stemming from disrespect and abuse in maternity care, should be sanctioned.*

Engage civil society—including women, youth and community groups—in monitoring compliance with quality standards and health coverage entitlements in both public and private facilities. *Brazil, for example, established health councils at all levels to monitor both public and private services, with representation specified at half from civil society, one-quarter from providers, and another quarter from government. An enabling context of good governance is required to ensure the effectiveness of such participatory review mechanisms. Social accountability platforms for health professionals and civil society can help drive improvements (see Panel 6).*

Extend private sector stewardship to multisectoral planning and monitoring systems addressing nutrition, NCDs, environmental health and other social determinants of health. *This should cover both domestic and transnational business operations, and be undertaken through inter-ministerial collaboration.*

PANEL 6. SOCIAL REGULATION OF THE PRIVATE SECTOR FOR PATIENTS' RIGHTS

SATHI is a civil society organization based in India that leads the Accountability of the Private Medical Sector Thematic Hub of COPASAH (Community of Practitioners on Accountability and Social Action in Health). This network was established in 2017 to protect patients' rights in developing countries, with a focus on South Asia.

In Maharashtra State, SATHI is spearheading social regulation through coalition-building among doctors, civil society activists and public health professionals who have exposed malpractice, campaigned for patients' rights and demanded effective regulation, grievance and redress mechanisms. A public hearing was convened, focusing on rights violations by public and private healthcare providers. The state government formulated a bill to regulate private clinical establishments, which includes a charter to protect patients' rights to information, access to their records, confidentiality, informed consent, non-discrimination and mandatory complaint mechanisms. Similarly, advocacy by the People's Health Movement has led to the inclusion of a charter of patients' rights in the national standards for clinical establishments, which applies to private hospitals.

Source: SATHI, India, based on submission to the IAP's 2018 Call for Evidence.

1.2. Parliaments should enact and strengthen legislation governing the parameters for private sector engagement in health, and ensure meaningful oversight and enforcement.

Under various international conventions and standards, "business respect for human rights is not a choice, it is a responsibility". States and corporations have the responsibility to protect and respect human rights, and to remedy violations. Without remedy and independent review and oversight by the judiciary, parliaments, ombuds offices and other national human rights institutions, and auditor generals to uphold the rule of law, there can be no meaningful accountability (see Panel 7).

In addition to adopting legislation—governing both for-profit providers and multinational corporations in countries where they are headquartered—parliamentarians have a responsibility to actively defend and monitor budgetary appropriations for women's, children's and adolescents' health; this includes providing the oversight mechanisms required. Strong, well-financed national human rights institutions would be positioned to effectively protect rights to health, covering both public and private sector actors.

Parliamentary committees should be tasked with reviewing legislation and adopting reforms to regulate the private sector's role in health care delivery as well as business impacts on health. This includes setting standards for government monitoring, contracting and licensing of private sector health goods and services, including through PPPs, and for managing conflicts of interest.

PANEL 7. LEGISLATION AND OVERSIGHT FOR PUBLIC HEALTH AND WELL-BEING

Protecting patients' rights: Independent focal points to receive and investigate patients' grievances should form part of any meaningful accountability system. Canada, for example, has a well-resourced ombuds office in the Province of Ontario that has positioned patients' rights as a health system issue, beyond individual grievances. Finland's Act on the Status and Rights of Patients mandates all health care facilities, public and private, to have an ombuds officer. Similarly, New Zealand's Code of Health and Disability covers the private sector.

Setting standards for procurement of private sector services: Legislative measures should regulate the terms for partnering with the private sector and managing conflicts of interest. For example, in the USA PPPs are legally registered as non-profits if they are to benefit from tax exemptions; thus they have to comply with reporting and can face fines for political activities. In Georgia, the law on procurement standards, its accompanying public electronic system and the role of the State Procurement Agency have contributed to making the country one of the highest-ranked by the Open Budget Survey.

Addressing supply chains: The Duty of Vigilance Law in France (2017), considered a landmark in business and human rights circles, obliges multinational companies to establish mechanisms to prevent human rights violations and negative environmental impacts across their supply chains. The private sector can also take the initiative: Sanofi, a pharmaceutical company, has committed to establishing an alert system against child labour across its supply chain, as well as complaint and early warning systems for non-compliance with its policies, including on workers' and patients' rights. Such corporate initiatives should be incentivized, while ensuring external validation of implementation.

Regulating the regulators: Legislation should ensure that public sector regulators' conduct is free of undue influence from both policy-makers and corporate interests. India's Supreme Court passed an order in 2011 on managing conflicts of interest among parliamentarians and policy-makers. Romania's Criminal Code goes further, making public officials liable for violations of conflict of interest standards. It applies broadly to all public sector institutions and private sector actors with government-delegated functions, including doctors and pharmacists.

Mandating corporate giving: India's amendment of the Companies Act requires large national corporations and foreign multinationals operating in the country to donate at least 2% of the past three years' average net profits to development initiatives. Companies can choose from one of nine focus areas, including three especially relevant to the Global Strategy: improving maternal and child health; eradicating hunger, poverty and malnutrition; and promoting education. Two years after the adoption of the amendment in April 2014, companies' charitable donations increased from 34 billion rupees in 2013 to around 250 billion rupees in 2016. However, 52 of the country's largest 100 companies failed to spend the required 2% in 2015. Even so, while still in its early stages, the experiment represents an innovative practice.

KEY MEASURES

Mandate independent accreditation of private health providers and require independent audits of facilities and insurance companies to ensure compliance with quality of care standards and entitlements under UHC schemes. *These measures should be applied as part of licensing, renewals, regular inspections and other regulatory mechanisms, and as a pre-condition for participation in health insurance schemes. Facilities and insurers should have transparent monitoring and reporting systems in place, and should make user-friendly information about service prices and entitlements publicly accessible. Regulation should extend to digital health technologies and data (for example, Internet sales of medicines and health products; provision of remote counselling and services; and to protect patient confidentiality).*

Establish or extend patients' rights charters to explicitly cover for-profit private providers, and require private sector facilities and insurance companies to have effective complaint and redress mechanisms. *Patients' rights charters and information on grievance and remedy procedures should be made publicly accessible and visible in health facilities, in user-friendly language. Independent oversight mechanisms should be designated to receive and investigate grievances (for example, ombuds offices and judicial, parliamentary, and professional associations with related mandates). Parliamentarians should convene public hearings on patients' rights in collaboration with national human rights institutions.*

Strengthen the mandate, authority, independence and capacity of the judicial system to enforce national legislation and human rights standards with respect to the private sector. *Courts play a critical role in ensuring compliance, by both national for-profit actors and multinational corporations in countries where they are headquartered. In Brazil, for instance, the Inter-American Court of Human Rights affirmed the state's constitutional duty to regulate private health actors in a case concerning a private psychiatric clinic. In Colombia, the Constitutional Court established jurisprudence on conscientious objection, ensuring women's rights to access abortion services in all public and private facilities.*

Establish legal measures to incentivize business sector contributions aligned with public health priorities. *This includes: creating a legal persona for social enterprises, if one does not yet exist, whereby the built-in incentives place health goals above, or at least on a par with profit motives; putting in place tax incentives for contributions to health; and mandating CSR financial contributions from large companies and multinational corporations.*

1.3. The UHC2030 partnership should drive political leadership and action at the highest level to ensure comprehensive national policies and transnational collaboration to address private sector accountability. It should position women, children and adolescents—and accountability for their health and rights—at the forefront of the global UHC agenda, and of decision-makers' mindsets at all levels.

A comprehensive approach is warranted, including but going beyond the roles of ministries of health, to involve a range of sectors in holding industries to account for their impacts on nutrition, environmental and other social and economic determinants of health. This should be achieved through close collaboration with other mechanisms and partnerships, especially those focused on NCDs and nutrition. This proposal is timely in light of the partnership's formalization of private sector engagement, including through representation on its Steering Committee and the establishment of a private sector constituency.