ISSUES IN CURRENT POLICY

Universal health coverage: necessary but not sufficient

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Abstract: In this article, we highlight key considerations for better addressing sexual and reproductive health and rights issues within universal health coverage (UHC), particularly in the context of the post-2015 sustainable development agenda. We look at UHC as a health, development and health care financing issue, and its history. We discuss its limitations as currently understood from a human rights perspective, and show why structural barriers to health and the legal and policy environment, which are essential to health (particularly to sexual and reproductive health and rights), require critical consideration in current discussions about health in the post-2015 development framework and must be taken into account above and beyond UHC in any future health goal. As a result, we suggest that UHC alone will not result in universal access to sexual and reproductive health, and certainly not to sexual and reproductive rights. Instead, it should be considered as a means to achieving broader health and development goals. A goal such as seeking to reach the highest attainable standard of health or maximizing healthy lives that is informed by a rights-based approach should be the aspiration for the post-2015 development agenda. © 2013 Reproductive Health Matters

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This article explores the promise and limitations of universal health coverage (UHC) with particular attention to its implications for the full realization of the right to health and sexual and reproductive health and rights. The urgency of securing sexual and reproductive health and rights was recently affirmed in the Report of the UN Secretary-General’s High-Level Panel of Eminent Persons on the Post-2015 Development Agenda (HLP report). The empowerment of women and gender equality is one of 12 proposed overarching goals in the HLP, and ensuring universal sexual and reproductive health and rights is one of five targets for the suggested goal to ‘ensure healthy lives’. The 2013 Millennium Development Goals report analyses MDG 5 (maternal and reproductive health), noting persistent gaps, and the fact that this goal is lagging far behind in its targets.

In its 2011 review of the ICPD Programme of Action (ICPD beyond 2014), the UN General Assembly passed a resolution which stressed that Member States should re-commit themselves to its goals and objectives at the highest level. It also extended the Programme of Action and Key Actions for its further implementation beyond 2014, to ensure that the goals and objectives are fully met.

The recognition of the importance of addressing health inequities and advancing sexual and reproductive health and rights is timely. Access to sexual and reproductive health and rights is a major element of the larger goal of securing
health as a human right on a basis of equality and non-discrimination, beyond both ICPD and the MDGs. But other major elements remain to be achieved too, i.e. that health care becomes accessible, acceptable, affordable, and of high quality, and is delivered in a non-discriminatory and equitable manner. This is closely linked to the conversations about UHC and the aspiration that all people can use needed health services – promotive, preventive, curative and rehabilitative – without financial hardship.

The WHO Constitution (1948) declares health to be a fundamental human right, reiterated in the Health for All Agenda (1978). The core elements of UHC are anchored in the right to health and enshrined in a number of international human rights norms and standards (e.g. the Covenant on Economic, Social and Cultural Rights, Convention on the Elimination of All Forms of Discrimination Against Women, Convention on the Rights of the Child and Convention on the Rights of People with Disabilities) and further guaranteed in many national constitutions, all of which make duty-bearers legally obligated to support people in the realization of their right to health (of which sexual and reproductive health are a part).

UHC is fast emerging as a priority in post-2015 development consultations. Previously, it was not only raised in the 20-year review of ICPD but also gained prominence at the UN General Assembly (as evidenced in GA Resolution A/67/L36). The World Health Report featured UHC in 2008, 2010, 2012 and 2013 reports. Indeed, the 2013 Report focuses on research on universal health coverage and expands the definition of UHC from “coverage” to “care”. However, in general, UHC has tended to focus on health coverage (ensuring protection from financial hardship) rather than universal health care for all.

In June 2012, the UN Conference on Sustainable Development, Rio+20, emphasized UHC’s role in enhancing not just health but also social cohesion, economic growth and development. It called for action on the social and environmental determinants of health and pledged to strengthen health systems towards the provision of equitable universal coverage, through a multi-stakeholder process. Then, in December 2012, the UN General Assembly recommended that UHC be included in discussions on the post-2015 development agenda, explicitly recognizing that “the importance of universal coverage in national health systems, especially through primary health care and social protection mechanisms, to provide access to health services for all, in particular for the poorest segments of the population”. Indeed, within the UN Development Group’s (UNDG) consultation process on the post-2015 agenda, UHC has featured prominently in the global thematic consultation on health, alongside reducing health inequities, addressing non-communicable diseases (NCDs) and safeguarding hard-won gains on the health MDGs. The UN Secretary-General’s High-Level Panel Report calls for “steady progress in ensuring Universal Health Coverage and access to quality essential health services.” It also calls for attention to synergies across different potential goals or priorities.

The report of the Sustainable Development Solutions Network (SDSN) proposes that “by 2030, every country should be well positioned to ensure universal health coverage for all citizens at every stage of life, with particular emphasis on the provision of comprehensive primary health services delivered through a well-resourced health system.” Current post-2015 policy discussions are primarily taking place within the Sustainable Development Goals Open Working Group.

Given UHC’s prominence, it is fitting to investigate how UHC can and should support other internationally agreed goals: universal access to reproductive health (MDG 5b) as well as the enjoyment of the right to health, free from discrimination, within emerging proposals for the new development agenda.

It is important to note in this regard that what is consistently being articulated as UHC is a commitment to universal health coverage (financial support for health care), rather than universal health care (or health for all), although the latter represents a more far-reaching goal. This paper takes up this distinction as a critical issue for advocates of the right to health.

What is UHC?

According to WHO, UHC means providing all people with access to affordable, quality health care services in order to ensure that they “obtain the health services they need without suffering financial hardship when paying for them.” UHC can contribute to the realization of the right to

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*At: http://www.who.int/whr/en/. Previous reports can be found at: http://www.who.int/whr/previous/en/.
health, and supports broader economic and social development agendas by making health services more affordable. The International Labour Organizations (ILO) further stresses that “universal coverage needs to ensure access to care for all residents of a country, regardless of the financing sub-system to which they belong.” According to UN General Assembly Resolution 66/288, it requires the “involvement of all relevant actors for coordinated multisectoral action to address urgently the health needs of the world’s population.”

Universal coverage is achieved when nearly everyone in a population is covered for almost all of their health needs irrespective of the costs involved (noting that virtually no country has yet achieved 100% coverage). In explaining the process of moving towards UHC, WHO has utilized the image of a three-dimensional cube (Figure 1) with three domains: population (who is covered), services (which services are covered), and direct costs (proportion of the costs covered). Coverage is primarily about removing financial barriers to care through suitable health financing mechanisms, which reduce out-of-pocket expenses and aim to eventually do away with these. Access, on the other hand, depends on various social determinants, as well as health systems factors such as sufficient service delivery points, drugs and equipment, and availability of primary, secondary and tertiary services and trained providers.

What UHC is not is a scheme to grapple with all aspects of ill-health, including the full gamut of social determinants of health. While essential, the focus on obtaining services without suffering financial hardship risks leaving aside the many ways in which services and access are constrained – whether because of health infrastructure, health personnel, social norms, or stigma and discrimination. These are crucial issues to address when assessing to what extent UHC helps achieve the right to health and universal access to sexual and reproductive health and rights. In reviewing this perspective, Gita Sen has offered a more nuanced framework, focusing on seven dimensions:

- financing and financial protection,
- health service norms (including essential packages),
- human resources for health,
- access to medicine and medical devices,
- management and institutional reforms,
- community participation and
- the social determinants of health.

Her framework points us toward the need to ask questions that have typically been left out of the UHC discussion.

UHC: some history

Over the past two decades, an increasing number of low- and middle-income countries, such as

![Figure 1. Three dimensions to consider when moving towards universal coverage](source: Adapted from 9, 10)
Brazil, India, Mexico, Rwanda, South Africa and Thailand, have started implementing programmes to provide UHC. The ILO has documented this growth, recording nearly 50 countries providing substantial social health insurance by 2008. The UN system, as well as e.g. the US Agency for International Development (USAID), Inter-American Development Bank, Bill and Melinda Gates and Rockefeller Foundations, have called for more attention to UHC. This call reflects a range of interests and perspectives: reducing or rationalizing health care expenditures, increasing health care and services in resource-poor settings, and securing the right to health – often bolstering the private health care system in the process.

Globally, there are different approaches to financing of universal coverage. Some countries have schemes in which every household is expected to contribute (as in Ghana, Rwanda, Philippines and Viet Nam). Others, such as Thailand, fund UHC through taxation in order to ensure coverage for all those outside the formal sector, as well as private insurance and government employee insurance.

Some supporters of UHC focus on promoting the right to health for all, while others emphasize health as essential to economic growth or to address political interests. The expansion of health care and health coverage is an inherently political process, connected to national debates about social welfare, social insurance and social development. The implementation of UHC as a national policy “has tended to require a confluence of political opportunities, available financial resources (mainly from a functioning tax revenue base), and the mobilization of strong, left political parties, leaders, and representatives (including trade unions)”. As per Gita Sen’s framework, it has required alignment along all seven dimensions identified by her.

**UHC as an economic development issue**

There is evidence that poor health and health care costs place a heavy burden on individuals as well as government budgets. The ILO estimates that people in low-income and lower middle-income countries, such as Cambodia, India and Pakistan, have to cover more than 50% of their own health expenditures whereas people in upper middle- and high-income countries shoulder under 30%. Of course, 30% is substantial and still represents a significant burden on households, especially those with limited resources wherever they live.

In fact, each year, up to 150 million people, many already vulnerable, face financial catastrophe because of direct payments for the health care they need.

Moreover, there is a documented relationship between income and access to health services at the country level, as high per capita GDP correlates with low health care deficit (i.e. lack of access to necessary health services). At the same time, the package of services covered by UHC is limited by national financial capacity, health infrastructure and national political consensus. Despite these financial limitations, by protecting against the potentially catastrophic financial impact of ill-health, UHC can strengthen the resilience of households and communities in the face of health shocks, helping them prevent and escape poverty. Poor health is a major driver of poverty. It reduces productivity and increases costs associated with seeking care. Conversely, the out-of-pocket costs of health care are a major factor driving people into poverty.

Financial protection is a cornerstone of UHC, helping people access care while protecting their savings, assets and livelihood. Seen in this way, it is both a health intervention and a poverty reduction measure. Mexico’s expanded coverage provides a compelling example. According to a 2005–06 assessment, the country’s national health insurance programme significantly reduced out-of-pocket spending and increased financial protection, especially for the poorest households. Eradicating poverty by 2030 – a proposed goal of the World Bank and the UN Secretary-General’s High-Level Panel – requires steady progress toward UHC.

In addition to being important in its own right, health is an indicator and driver of development. Thus, three of the eight MDGs are about health. Where UHC expands access to much-needed health services, such as HIV antiretroviral therapy or improved management of diabetes and other chronic conditions, the well-being and productivity of people, households, communities and nations are enhanced. In Mexico, for example, expansion of health coverage increased access to antenatal and childbirth care and contributed to significant declines in child mortality. Mexico is thus projected to reach the MDG 4 target before 2015.

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*Maternal mortality declined in Mexico from 90.4 per 100,000 live births in 1990 to 51.5 in 2010. Mortality in children under five fell from 47.1 per 1,000 live births in 1990 to 16.7 in 2010.*
In this context, some have argued that health is essential not only to economic development, but also to sustainable development, with UHC as a key means to achieving this. However, this still requires accompanying measures to “ensure that the health services people need are available and of good quality; that the health workers needed to deliver them are well trained, motivated, and close to people; and that the drugs and equipment they need are available and distributed appropriately.” This is an important reminder that health service norms and capacity are also key elements in increasing health equity.

**UHC as a health care financing issue**

UHC can particularly benefit those with chronic diseases, such as HIV, diabetes and cardiovascular disease, and particularly those who are poor, as those who are wealthier and/or employed may be covered through government or private sector health insurance schemes. In Thailand, for example, prior to 2001, various forms of protective pre-payment systems and fee exemptions, reached only 70% of the country’s poor, near poor and uninsured. With a goal of covering all Thai citizens, the Thai Government introduced a new scheme in 2001. By 2005, it had increased use of inpatient care among the poor by 8–12%. Many low-income countries struggle with inadequate domestic revenues to ensure universal access to a basic package of health services, even if their governments are committed to guarantee health care for all. For a county like Mali or Ethiopia, the overall public revenues collected through taxes, royalties, and other means, amounts to around 20% of national income, which is equal to US $60 per person per year for all development sectors, including health. Where external money is received to fund essential services, other challenges (such as government capacity to effectively coordinate) may exist. In many countries, fragmentation of health financing from different sources such as donors, government and civil society also constrains joined-up health service delivery. A study in Zambia, for example, found that harmonization of funding sources under a single framework strengthened efforts to achieve broader health coverage.

However, while UHC should reduce the direct costs of health services covered, it does not a priori replace indirect costs, such as lost income from reduced employment or productivity experienced by people who are ill and those providing them with care. Nor does it mitigate the burden of extra household expenditure, asset depletion and debt accumulation from poor health and/or non-covered costs (e.g. transportation costs). Nor does it protect people from stigma and discrimination due to poor health, which may adversely affect access to employment, justice and other social services. In sum, poor health has many potentially negative consequences; financial protection through UHC addresses but one.

Finally, as stated in the 2010 World Health Report, “Pooled funds will never be able to cover 100% of the population for 100% of the costs and 100% of needed services. Countries will still have to make hard choices about how best to use these funds.”

**UHC as a human rights issue**

The right to the highest attainable standard of health is enshrined in the core international human rights norms and standards as well as in national constitutions. Efforts to realize rights necessarily extend beyond services and commodities and draw attention to other social determinants of health and issues of discrimination within the health system. Moreover, the discussion of human rights encompasses the question of accountability. Coherence in accountability mechanisms that oversee human rights and health commitments, securing broad participation of women and other marginalized groups, along with transparency and accountability in resource monitoring are critical complementary aspects to the achievement of UHC. These are particularly important given the current debates around appropriate accountability mechanisms and methods for monitoring compliance with development commitments in the light of human rights obligations.

UHC is a commitment that all people have access to health care and services regardless of gender, ethnicity, class, religion, sexual orientation, gender identity, social origin or any other factor. The right to the highest attainable standard of health is set out in Article 12 of the International Covenant on Economic, Social and Cultural Rights and anchored in the idea of accountability on the part of governments and others, that they have discharged their obligations and had a chance to explain what they have done and why. The full enjoyment of this right is dependent on the right to be free from discrimination and also on the
extent to which UHC promotes access to good quality services, whether it is founded upon and/or promotes community participation, and whether it takes into consideration the social determinants of health in delivery of services. There are a range of views from all sectors about what should be included in rights-based UHC, such as strengthened public health systems,31 good governance, and attention to gender, generation and geography,32 state obligation and accountability mechanisms,33 fairness, equitable access to good quality care and essential medicines.34

The shift to framing the goal as the ‘enjoyment of the highest attainable standard of health’ in the Alma Ata Declaration of 197835 was also anchored in a larger debate about human rights, stemming from reactions to World War II that went far beyond health.

Several other human rights norms and standards can be helpful in understanding how to translate the right to health, to non-discrimination, and indeed, the full range of human rights, to the UHC context. These include the norms of progressive realization, non-retrogression, and minimum standards, all of which hold that while resources may be limited, States Parties still have a duty to fulfill their human rights obligations – even if there is a distinction between short- and long-term implementation.36,37 General Comment 14, Article 12.2 in the International Covenant on Economic, Social and Cultural Rights clarifies that: “The right to health is not to be understood as a right to be healthy. The right to health contains both freedoms and entitlements. The freedoms include the right to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health” (emphasis added).30 Finally, the principle of non-retrogression means that States Parties cannot retreat on the level of obligations that they have already fulfilled.37

Evidence that universal health coverage is necessary but insufficient to achieve health goals

Countries that have advanced in implementation of UHC still face unresolved challenges, such as persistent health inequities (linked to social determinants of health and/or discrimination) and inadequate quality of services (due to inadequate health infrastructure or a mismatch in health care personnel and health care needs). Thus, while Brazil, Mexico and Rwanda’s universal health coverage policies show increasing utilization of services, major shortcomings remain.

In Mexico, inequality and inequities in availability of health resources persist across states and within states – and rural vs. urban areas – that lead to differences in health outcomes. For example, while the Seguro Popular has advanced prevention, early detection, and treatment of cervical cancer, this is not evenly distributed across the country: incidence and death rates remain higher in the poorer, southern states than elsewhere in the country.24 Moreover, in 2012 the infant mortality rate in the state of Nuevo Leon was estimated at 9.4 per 1,000 live births as compared to 18.6 in Guerrero. Maternal mortality in Tlaxcala was 27 per 100,000 live births while in Oaxaca it was 99.34,38

Similar patterns of inequity can be observed in Rwanda. Whereas the Rwandan Community Based Health Insurance Programme (Mutuelle), has substantially increased service utilization and reduced the risk of catastrophic health spending for beneficiaries, enrollees in the poorest quintile still had significantly lower rates of utilization and higher levels of catastrophic health spending than those in higher quintiles.34 And in Brazil, even with its well-developed universal health coverage system, there are age disparities in access to pregnancy care for adolescents and young women even though more than 20% of all infants in Brazil in 2008 were born to adolescent mothers.39

Access to services does not automatically guarantee quality of services, nor that these services meet the human rights standard in the International Covenant on Economic, Social and Cultural Rights of ‘3AQ’ (accessibility, affordability, acceptability and quality). In Thailand, for example, where a policy of UHC has been in place since 2002, shortages and poor distribution of trained health professionals have been cited as the greatest barriers to fulfilling universal access.40 An analysis of health insurance for informal sector workers in Nicaragua found that the intended impacts were not achieved, at least partly because quality of care in service delivery was not tackled.41 In resource-constrained settings across the world, UHC requires calibrating
the extent of coverage in order to ensure quality of care in the services provided.

**UHC as a means to an end but not the end in itself**

Many of those advocating UHC see it as an achievable step towards the longer-term goal of realizing the right to health for all and ensuring healthy lives. Changes in life expectancy and other health outcome indicators can take generations to achieve, whereas process-related targets such as UHC are more achievable within the 15–20 year timeframe likely with any new development commitments. Thus, for many in the sexual and reproductive health and rights community, UHC may be a tactical objective serving a broader human rights goal. This means complementary measures are needed alongside UHC in order to maximize health outcomes, reduce health inequities, and accelerate progress on broader development objectives. Two key measures are action on the social determinants of health and implementation of other social and legal protections.42–45

Underlying social determinants that drive persistent inequities include levels and distribution of income, education, housing, nutrition and safety, which are themselves rooted in social norms, laws and policies and governance arrangements. Social determinants may directly influence risk behaviours, such as unsafe/unprotected sex, poor diet, lack of physical activity, and use of drugs, tobacco and alcohol. They also prevent people, especially those who are vulnerable and marginalized, from accessing health services even when services are available and free. Punitive laws, for example, continue to prevent groups such as people living with HIV, men who have sex with men, transgender people, and sex workers from accessing antiretroviral therapy, despite remarkable global progress in scaling up HIV treatment access in 2012.

Action outside the health sector can positively influence behaviours, remove barriers to health services and, ultimately, improve health outcomes, e.g. through improvements in social conditions, housing and nutrition, which drove dramatic declines in the prevalence of tuberculosis in higher-income countries prior to the advent of effective anti-TB medicines.46–48 Tobacco taxes and smoke-free zones – both requiring coordinated multisectoral action – are key weapons in the fight against tobacco-related illnesses.49 Cash transfers are another potentially promising area for multisectoral action. They can increase uptake of health services, influence risk behaviors, improve health outcomes,50,51 increase HIV treatment adherence and retrieval of HIV test results.52,53 Recent studies have also highlighted how cash transfers can change HIV-related risk behaviors, especially amongst young women, resulting in significant declines in HIV prevalence or proxies for HIV risk.54,55

In addition to action on social determinants of health, social and legal protection measures are needed alongside UHC in order to realize equal and equitable access to health care, including for sexual and reproductive health problems, as well as universal health coverage. Examples include pension schemes, housing subsidies and regulations protecting employment and labour conditions.

Often social and cultural norms, as well as restrictive laws and policies, hinder access to health services, rather than facilitating it, e.g. laws that criminalize consensual sex between same-sex partners (in effect in 78 countries), sex outside marriage, or sex work, as well as laws that prevent access to safe abortion, including through age of consent laws that prevent young people from seeking sexual and reproductive health information, as well as health services.56

**Implications for sexual and reproductive health and rights**

Sexual and reproductive health and rights may be systematically neglected in many ‘essential services packages’ but we contend that three factors in particular require attention within and beyond the health sector to secure sexual and reproductive health and rights for women: accessibility, national legal and policy frameworks and social norms. Indeed, TK Sundari Ravindran finds systematic gender-related obstacles at every level, which include women’s out-of-pocket payments being systematically higher than men’s, due in part to the high costs of paying for antenatal and delivery services, and hampered access due to women’s constrained mobility and access to resources.57 Finally, a shortage of female health care providers, limited hours of service provision, and lack of childcare also impede women’s access to services.58

Other examples of overt discrimination include laws that deny women the right to consent to...
medical treatment, or require them to get permission from their parents or husband to obtain birth control. Such discriminatory laws and policies may very well counteract any gains that UHC attempts to bring. Similarly, some laws and policies may be directly contradictory to globally agreed health goals. For example, in 2008, 98% of countries allowed abortion in order to save a woman’s life, whereas only 28% of countries permitted abortion on request. And although MDG 5a is about reducing maternal deaths, reducing the 13% of maternal deaths due to unsafe abortion is almost never considered part of how to achieve the reduction.

**Universal health coverage and the post-2015 development agenda**

Despite many calls for action and UN commitments, progress on sexual and reproductive health and rights lags behind the other MDGs. While some countries have shied away from fulfilling their obligations of delivering sexual and reproductive health services on the basis of political or religious opposition, others have simply failed to consider women’s needs and rights as a priority because of social norms that subordinate women. In still others, the policies exist on paper but too few resources are committed to make them a reality. Unfortunately, the MDGs lack specific language and frameworks for addressing many of the sensitive issues that sexual and reproductive health and rights encompass, especially in relation to sexuality and gender. This gap was addressed in the 2005 World Summit when world leaders recognized that the exclusion of targets and indicators related to sexual and reproducive health was holding back progress not only in maternal health, but in tackling HIV, improving gender equality and child survival, and reducing poverty.

A promising development in this vein, especially in terms of strengthening accountability at the national level in the context of MDG 5, is the Commission on Information and Accountability for Women’s and Children’s Health. The Commission’s accountability framework includes indicators for results and resources, as well as an action plan to improve health information. Meanwhile, men’s sexual and reproductive health needs remain almost invisible.

The framing of health in the post-2015 development agenda is crucial not just for achieving the right to health but also for achieving sexual and reproductive health and rights. We conclude from the evidence that UHC should be considered as a means to achieving broader health and development goals. Hence, the health goal might best be framed in the post-2015 sustainable development agenda in terms of achieving the highest attainable standard of health or maximizing healthy lives. The United Nations Development Group (UNDG) global thematic consultations on health and the UN Secretary-General’s High Level Panel have proposed such an overarching goal. The benefits are clear: the focus would remain on the ultimate objective of maximizing health while ensuring a rights-based, equitable approach to health systems strengthening and good quality health services. Such an approach to health would be transformative indeed.

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**References**


Résumé
Cet article met en évidence les principaux éléments à considérer pour mieux aborder les questions de santé et de droits sexuels et génésiques dans le cadre de la couverture sanitaire universelle (CSU), en particulier dans le contexte du programme du développement durable de l’après-2015. Nous examinons la CSU comme thème du développement sanitaire et du financement des soins, et son histoire. Nous discutons de ses limites telles qu’elles sont actuellement comprises dans une perspective de droits de l’homme. Nous montrons pourquoi les obstacles structurels à la santé, et l’environnement politique et juridique, essentiel pour la santé (en particulier pour la santé et les droits sexuels et génésiques), doivent être examinés de manière critique dans les discussions actuelles sur la santé dans le programme du développement de l’après-2015 et doivent être pris en compte en allant au-delà de la CSU dans tout objectif futur relatif à la santé. Par conséquent, à notre avis, la CSU n’aboutira pas seule à un accès universel à la santé sexuelle et génétique, et certainement pas aux droits sexuels et génésiques. Elle devrait plutôt être considérée comme un moyen de parvenir à des objectifs de santé et de développement élargis. Le programme de développement de l’après-2015 devrait aspirer à atteindre un objectif, étayé par une approche fondée sur les droits, tel que la jouissance du meilleur état de santé ou d’une vie aussi saine que possible.

Resumen
En este artículo se destacan consideraciones clave para tratar mejor los asuntos de salud y derechos sexuales y reproductivos relacionados con la cobertura sanitaria universal (CSU), en particular en el contexto de la agenda de desarrollo sostenible post-2015. Consideramos la CSU como un asunto de desarrollo en salud y de financiación de servicios de salud, y estudiamos su historia. Discutimos sus limitaciones tal como se entienden actualmente desde el punto de vista de derechos humanos, y mostramos por qué las barreras estructurales a la salud y el ambiente legislativo y político, que son esenciales para la salud (en particular la salud y los derechos sexuales y reproductivos), requieren consideración crítica en las deliberaciones sobre la salud en el marco de desarrollo post-2015 y deben tomarse en cuenta más allá de la CSU en todo futuro objetivo relacionado con la salud. Por consiguiente, sugerimos que la CSU por sí sola no basta para garantizar acceso universal a servicios de salud sexual y reproductiva, y menos a los derechos sexuales y reproductivos. Debe considerarse como un medio para lograr metas más generales en salud y desarrollo. La aspiración para la agenda de desarrollo post-2015 debería ser una meta como procurar alcanzar el más alto nivel posible de salud o maximizar el número de vidas saludables, en la cual influya una estrategia basada en derechos.