ARE THE SUS AND THE RIGHT TO HEALTH INCOMPATIBLE WITH UNIVERSAL HEALTH COVERAGE?

Challenging Misconceptions Around the Concept of UHC in the Public Health Scholarship in Brazil

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ABSTRACT

The literature on public health in Brazil has criticized the idea of universal health coverage (UHC), arguing that UHC is incompatible with the universal health system and the right to health. This article assesses that criticism and concludes that it creates a "strawman" argument. The idea of UHC that is being criticized in Brazil bears little similarity to the concept of UHC promoted by international organizations and discussed in the international literature.

KEYWORDS: *Universal health coverage (UHC); right to health; universal health systems; United Nations (UN) sustainable development goals (SDG); Brazil*

O SUS e o direito à saúde são incompatíveis com a cobertura universal de saúde? Críticas e equívocos a respeito da UHC na literatura em saúde pública no Brasil

RESUMO

A literatura sobre Saúde Coletiva no Brasil tem criticado a ideia de cobertura universal de saúde (UHC) porque UHC preconizaria um modelo de saúde incompatível com o Sistema Único de Saúde (SUS) e com o direito à saúde. Este artigo analisa os fundamentos dessa crítica e conclui que ela se sustenta em uma "falácia do espantalho". A ideia de UHC à qual os críticos se opõem guarda pouca semelhança com a ideia de UHC defendida por organizações internacionais e discutida na literatura internacional.

PALAVRAS-CHAVE: *Cobertura universal de saúde (UHC); direito à saúde; sistemas universais de saúde; metas de desenvolvimento sustentável da Organização das Nações Unidas (MDS-ONU); Brasil*

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INTRODUCTION[1]

Half of the world's population lack access to adequate health services, and many must sacrifice a large part of their income in order to receive them, leading millions into extreme poverty (World Health Organization, 2019). In response to this context, several inter-

national organizations have recognized the need to achieve universal health coverage (UHC).

UHC has been included in the United Nations sustainable development goals (UN-SDG), which all member countries are committed to achieving by 2030. UHC, as defined in the UN-SDG, includes "protection against financial risk, access to good quality, essential health services, and access to essential drugs and vaccines that are safe, effective, of good quality and at prices that are accessible to all".

There is no single definition of UHC. Resolution no. 67/81 of the UN General Assembly, for example, has a definition similar to that of the UN-SDG, but refers to "access to a nationally determined set of services". The World Bank, the Organization for Economic Cooperation and Development (OECD), Unicef and the latest publications of the World Health Organization (WHO) all present a broader and simpler definition: all people receiving quality health services that meet their needs without exposing them to financial hardship in paying for them (Ottersen *et al*., 2014; WHO, 2010; WHO; IBRD/World Bank, 2017; WHO *et al*., 2018; Unicef, 2016).

Despite the differences, it can be said that all definitions of UHC present a notion of universal and equal access to health services without incurring financial risks for patients. In other words, access to health services must be disconnected from the economic means of the user so as to avoid the risk of needed care not being received in the event that an individual is unable to pay for it, or to prevent health care expenses aggravating or pushing people into poverty. This is only achievable through a system of risk sharing, social solidarity (where those with greater financial capacity subsidize the worse-off) and forms of financing that do not depend on patients paying directly for services.

The support from international organizations for UHC, creating a common agenda around this concept, has been followed by a vast academic literature (mainly in English) that brings together specialists from different fields. Despite the different ways of interpreting UHC, Abiiro and De Allegri (2015) claim that there is a "global consensus" on its importance.

However, enthusiasm for UHC at the international level appears to stand in contrast to the perceived low take up, or even rejection, of the concept in the literature on health in Brazil. In the first part of this article, I will examine this perception through a review of this literature in order to understand in which types of publication the concept appears most often and how authors perceive it. If the hypothesis of resistance to the concept of UHC is confirmed, the second part will analyse the basis of the criticisms levelled at the concept and their validity.

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METHOD

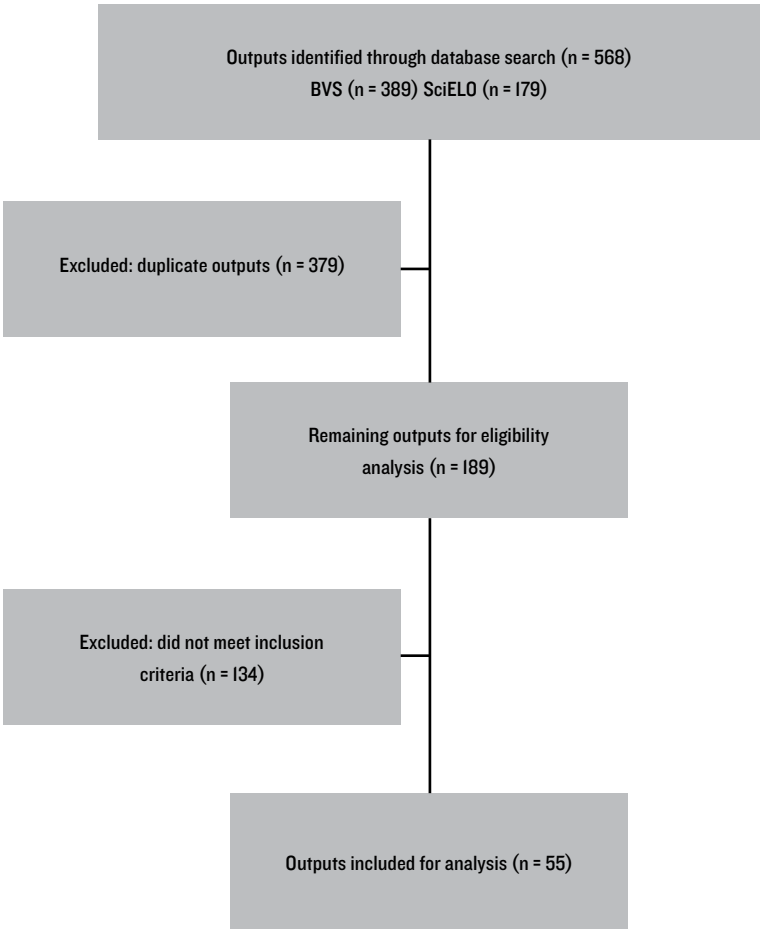
The review of the literature was carried out using the databases of the Biblioteca Virtual em Saúde [Virtual Health Library, BVS] — Regional Portal, and the Scientific Electronic Library Online (SciELO). In the BVS databases, a filter was applied to only show the publications included in the Lilacs and Medline databases. Both in the BVS and in SciELO, two searches were carried out, one using the Portuguese terms "*cobertura*", "*universal*" and "*saúde*" concurrently, and the other using the English equivalents: "universal", "health" and "coverage". In terms of where these terms were located, standard configurations were used in the searches, which in the BVS database refer to "title, abstract and subject" and, in the SciELO database, "all indexes". In all searches, a filter was applied to limit the results to texts published in Brazil. The SciELO database offers a specific filter for this ("Collection: Brazil"), while in the BVS database the same can be achieved using the operator cp: "BRASIL". The timeframe of the research refers to the period between 2005 (the year of the publication of Resolution 58.33 of the World Health Assembly, which launched the concept of UHC) and May 11, 2019, the date on which the results were consolidated.

The searches carried out in the BVS database with the terms in English returned 232 results, while with the terms in Portuguese returned 157. In the SciELO database, the results were 92 and 87, respectively. In total, these searches furnished 568 results, of which 379 were eliminated because they were duplicated. Subsequently, an eligibility analysis was carried out, in which the following were excluded:

(I) article whose full content is not available (n = 1);
(II) graduate theses/ dissertations (n = 25);
(III) non-academic publication (n = 1);
(IV) studies that do not explicitly address the concept of "universal health coverage" (n = 107).

The 55 results included for analysis were classified according to the year of publication, the type of publication (book or journal) and the health speciality addressed. The results were then classified into three normative positions with respect to universal health coverage. The first position is critical of the concept, understanding UHC as limiting or harming the right to health or the universal health system. The second is of endorsement, in which the authors accept universal coverage as a goal to be achieved or as a valid parameter for evaluating health systems and policies. The third position is of neutrality: the idea of universal coverage is used to describe a health system, and not

FIGURE 1
Results of searches in databases and papers selected for analysis



Source: Elaborated by the author.

as a goal to be achieved. It is possible that the works in this third position employ "universal health coverage" in the legal sense of having the right of access to a health system, and not the broader concept of UHC measured by effective access. However, for reasons of transparency, these studies were included in the analysis.

RESULTS

Although the small number of results does not allow us to draw strong conclusions about the distribution of outputs over time, it is clear that it was from 2014 onwards that the idea of UHC began to appear more intensely in the Brazilian literature on health (Table 1).

The results show that, among the 55 studies analyzed, 35 (64%) endorsed UHC, 12 (22%) were critical of the concept, while 8 (14%)

TABLE I
Distribution of results according to position and year

Position	2007	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total
Critical	0	0	1	0	1	1	2	1	2	4	0	12
Endorsement	0	1	2	0	0	4	3	14	8	0	3	35
Neutral	1	0	0	1	0	1	1	1	1	2	0	8
Total	1	1	3	1	1	6	6	16	11	6	3	55

Source: Elaborated by the author.

were neutral. These results would seem to indicate that the aforementioned perception that UHC is widely rejected in Brazil is mistaken. However, when the results are divided by health speciality, the picture becomes more complex.

Most of the results (84%) come from publications in the fields of "nursing" and "public health" (Table 2). It is surprising that there are more studies mentioning UHC in the field of nursing than in public health, considering UHC has greater thematic proximity to the latter and would, therefore, be expected to be more influential as a concept. Furthermore, according to data from the Coordination for the Improvement of Higher Education Personnel (Capes), there is a significantly larger number of publications in the area of public health than in that of nursing (Capes, 2017b, 2017a).

While nearly all works in the field of nursing endorse UHC, and many make direct mention of WHO studies and guidelines on the topic, almost half of those in public health are critical of the concept. It is relevant that 83% of the critical works come from the field of public health, which shows that objection to UHC is largely concentrated in this area. Furthermore, with the exception of Medici (2011), the works that endorse UHC do not offer more detailed analysis or defence of the concept, but rather accept it as a theoretical reference or starting point for discussion. Critical studies, meanwhile, tend to be more incisive and centered on opposition to UHC (Annex).[2] Therefore, in the public health literature, criticism of UHC is greater, both in frequency and intensity, than endorsement.

The data show that one cannot speak of resistance to the concept of UHC in the health literature in Brazil as a whole, although there is strong opposition to it in the field of public health. This helps to explain the relatively low number of papers in this area that mention UHC, as scholars are less likely to investigate a concept that they, and a large part of their epistemic community, are opposed to, let alone use it as a theoretical framework or engage with the literature that does.

[2] Available at: <https://cebrap.org.br/wp-content/uploads/2020/11/Anexo-1.docx>.

TABLE 2
Distribution of results according to position and area

Position	Surgery	Health communication / education	Health law	Nursing	Biomedical research	Public/collective health	Occupational health	Total
Critical	0	1	0	1	0	10	0	12
Endorsement	1	1	1	24	1	7	0	35
Neutral	2	1	0	0	0	4	1	8
Total	3	3	1	25	1	21	1	55

Source: Elaborated by the author.

DISCUSSION

The results of the literature review contradict the thesis of a "global consensus" around UHC. The public health literature in Brazil make relatively little use of this concept, and a significant part of it has explicitly expressed opposition to UHC. It is thus necessary to analyze the grounds for such a rejection of a concept that arouses considerable enthusiasm in the international literature and in international organizations. As well as the critical studies already identified in the literature review, the discussion will also include a paper by Ocké-Reis, which, although not included in the researched databases, deals specifically with UHC and is cited in other references.

Critics tend to counterpose UHC to universal health systems and the right to health. From this perspective, UHC is understood as offering a very limited notion of the rights of users and the duties of the state. They associate the universality of UHC with the idea of "packages" or "baskets" of services, two-tiered health care access, and financial protection against catastrophic expenditure via private health insurance. By contrast, universal health systems such as the Brazilian National Health System (Sistema Único de Saúde - SUS) promote universal, comprehensive and integrated health care joined with equality and the recognition of health as a right that entails responsibilities for the state. As stated by Castillo and colleagues (2017), the "universal health coverage mantra thus conceals exactly the opposite of its real meaning: a non-universal, non-integrated/comprehensive, non-public and non-free health program". Therefore, promoting UHC in the Brazilian context is equated with advocating the dismantling of the SUS and abandoning the idea of health as a human right in favor of expanding the private health market. Universal health coverage is thus seen as a neoliberal alternative to social rights and the SUS.

This criticism of UHC, which opposes it to universal health systems and the right to health, rests on a "strawman" fallacy: the position

that is to be refuted is presented in an inaccurate or distorted way that exaggerates some aspects while ignoring others. As will be discussed in the following sections, the way critics present UHC in order to refute it has little to do with what international organizations and the specialist literature have developed and advanced.

UHC and universal health systems

The opposition between UHC and universal health systems assumes that these are two distinct and incompatible models of health system. From this perspective, UHC is presented as an alternative to universal systems because, allegedly, it advocates a reduced role for the state, exempting it from the responsibility to provide services in a universal and equal way, so that its role is reduced to merely regulate and subsidize insurance, covering a minimum basket to those unable to buy it on the market (Giovanella *et al.*, 2018; Castillo *et al.*, 2017; Magno, 2015). Health care would thus be primarily left to the private insurance market, which inevitably grows in the absence of a public system and the injection of public resources (Giovanella; Rizzotto, 2018; Giovanella *et al.*, 2018; Laurell, 2016). Universal health coverage therefore would favor market mechanisms and the fragmentation of the health system, thus aggravating health inequalities (Asociación Latinoamericana de Medicina Social, 2018; Castillo *et al.*, 2017; Laurell, 2016; Barros; Negri Filho, 2015; Ocké-Reis, 2016).

However, the relationship between universal systems and UHC is not that of competing and mutually exclusive alternatives, but of means and ends. Universal health coverage is a set of goals to be achieved, not a particular type of health system (Kutzin, 2013). Countries can reach UHC in several ways — including, but not limited to, a universal health system along the lines of the SUS. The UHC literature does not prescribe universal systems funded primarily or solely by taxes, but neither does it exclude them. The World Bank, acknowledging the plurality of health systems, affirms that "there is no single path to UHC" (The World Bank, 2015). In the same vein, the WHO also does not identify a single, nor best, type of health system to reach UHC, and considers that this choice must be made according to the economic, sociocultural and political context of each country (WHA, 2015).

This consensus on the goals and agnosticism on the means of attaining them is reasonable. It is possible to offer universal and equal access to quality health services without exposing people to financial risks through universal tax-financed systems (eg, Canada and the United Kingdom), through public insurance funded by social contributions on the payroll with state support for those outside the formal labour market (eg, Germany and France), or through highly regulated private insurance with compulsory membership and public and cross-

-subsidization (eg, Holland and Switzerland). The only type of health system incompatible with UHC is one based on voluntary health insurance (Jamison *et al.*, 2013; Oxfam, 2013). Although such a system is preferable to direct (out-of-pocket) payments, the literature does not regard it as a long-term solution, and its existence should not be reason to reduce public investment in health (Kutzin, 2012).

Universal health coverage by no means imply that the role of state should be reduced to make way for market mechanisms. On the contrary, to avoid fragmentation of the system and achieve greater efficiency and equity, it requires state action to create compulsory contributions and risk-sharing mechanisms (either through single universal systems or public or private compulsory insurance) (Kutzin, 2013; WHO, 2010a).

Universal tax-financed public systems are not the only arrangement capable of fostering UHC, although their examples are often mentioned as models to be followed (Martin *et al.*, 2018; Oxfam, 2013). Brazil is, in fact, considered one of the pioneers in recognising UHC as a human right for having constitutionalized the right to health and created the SUS (The World Bank, 2014). Therefore, it is possible to adopt the concept of UHC and, at the same time, argue that universal systems such as SUS are, in the Brazilian context or in general, the best way to achieve UHC. It can also be argued, as Kutzin and Oxfam have, that the existence of private or public insurance segmented by groups creates inefficiencies and inequality and, therefore, are an obstacle to UHC (Kutzin, 2013; Oxfam, 2013). What does not make sense is to start from the premise that UHC and universal systems are conceptually incompatible or contradictory.

UHC and access and use of health services

Some authors also criticize UHC based on the distinction between "universal coverage", the goal of UHC, and "universal access", to which universal systems are committed. "Coverage", according to critics, means a formal link to an organization that has responsibility for providing some kind of health care. However, the argument goes, this formal recognition does not necessarily mean the possibility of "access" and "use" of services that adequately meet the needs of patients (Buss *et al.*, 2014; Noronha, 2013; Ocké-Reis, 2016). In other words, a population may be formally covered by a system, but unable to access and use the services it needs.

True, formal coverage does not necessarily guarantee access and use. However, "coverage" does not need to have such a narrow meaning. There are other uses of the term that also comprise access and use. This is the meaning of "access", for example, when talking about vaccination coverage, which is calculated as the ratio between the num-

ber of people effectively immunized and the total population. Or in analyses of the coverage of the Family Health Strategy (FHS), a key primary care programme in Brazil, measured by variables such as the percentage of households registered in local health centres and receiving visits from health agents (Malta *et al.*, 2016). Even when critics recognize the multiplicity of meanings of "coverage", they are suspicious that such an ambiguous term could hide the real intentions behind the idea of UHC (Laurell, 2011).

It is not clear, however, why critics consider that when used in connection with UHC the term "coverage" should refer to its most restrictive, formal sense, which distances itself from the concepts of "access" and "use". In reality, the evidence points in the opposite direction, with international organizations defining UHC using the terms "access to service" or "receiving/obtaining services" (Ottersen *et al.*, 2014; WHO, 2010b; WHO; IBDR/The World Bank, 2017; General Assembly of the United Nations, 2012; WHO, 2015). Furthermore, the understanding of coverage as "effective coverage" is explicit: the percentage of people who need a given service and actually receive it (De Paz *et al.*, 2017). Indicators adopted to measure countries' progress towards UHC also focus on the proportion of people who actually receive the services they need (WHO; IBDR/The World Bank, 2017; De Paz *et al.*, 2017; Hogan *et al.*, 2018). Other UHC indicators go even further than simple access to include data on whether the treatments received produce the expected health outcomes. For example, instead of just measuring the HIV-positive population who received antiretrovirals, the proportion of those who saw a reduction in viral load is also measured (WHO; IBDR/The World Bank, 2017).

Therefore, the distinction between "coverage", "access" and "use" makes no difference in the context of debates about UHC. International organizations and the specialist literature unequivocally use "coverage" to also mean "access" and "use".

UHC and service packages

Universal health coverage is also criticized for its supposedly limited reach, by seeking to guarantee coverage for only a "minimum package" or a "limited basket" of services for the poorest (Giovanella *et al.*, 2018). These packages (or baskets) are understood to generate inequality because the poor are offered only the minimum, while the wealthy have access to more services via the market. Critics also disapprove the idea that these packages should be determined using cost-effectiveness criteria (Uribe-Gómez, 2017). Universal systems, by contrast, are supposedly guided by the principles of equality and integrated care in which there are no limited baskets, and services are offered according to the needs of patients.

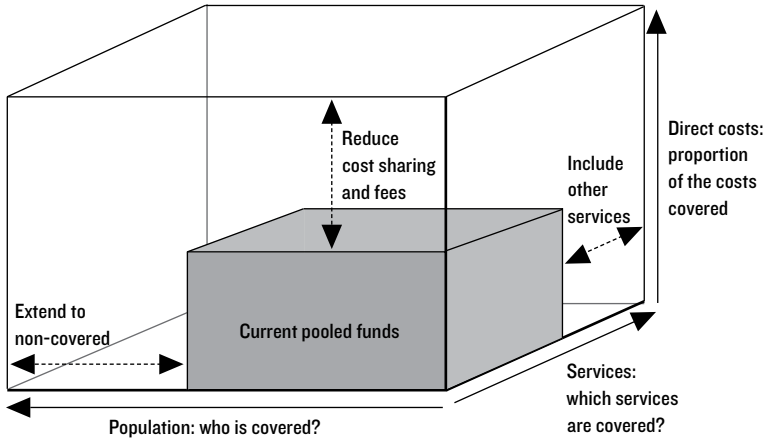
Criticisms of service packages are closely linked to the idea that UHC advocates a segmented health insurance system in which access is primarily gained via market mechanisms. As we have seen, this is a mistaken view of UHC. However, the idea of determining a set of services to be offered to the population does appear in discussions about UHC and stems from the correct assumption that no system in the world can provide all services to the entire population for free and, therefore, choices must be made (Ottersen *et al.*, 2014; Horton, 2018).

The mismatch between the population's health demands and the capacity of systems to meet them creates limits to what is offered to the population, both in practice and in law. In Brazil, despite the existence of the SUS, there is a large supplementary private health system that covers about 30% of the population and a high proportion of out-of-pocket payments, which forces families to spend a significant part of their income on health care (Organization for Economic Co-operation and Development, 2016). Discussions around the Mais Médicos [More Doctors], a program to reduce the shortage of general practitioners in deprived areas of Brazil, show the challenges for the SUS to universalize even primary care (Campos; Pereira Júnior, 2016). Even much better funded universal systems have limitations. Canada, which provides universal access to hospital care, lacks a national pharmaceutical policy. There are regional variations in the public funding of medicines and a significant part of expenditure on drugs is made through complementary private insurance or by out-of-pocket payments (Martin *et al.*, 2018). In the United Kingdom, whose health system inspired the SUS, effective drugs may not be provided or access may be rationed for reasons of cost-effectiveness or budget impact (National Institute for Health and Care Excellence, 2012; 2018).

The literature on UHC accepts that the scarcity of resources constrains health systems, but what UHC aspires to is ambitious. The famous WHO cube (Figure 2), which specifies the three dimensions to be considered by UHC, shows that the ultimate goal is for all people to be covered (maximum universality), to access all the services they need (maximum coverage) without having to pay for the service used (maximum financial protection). All countries start somewhere (represented by the smaller grey cube) and the UHC goal is to fill the larger cube, but scarcity imposes choices about priorities along the way. Although the aim should be to offer an increasing number of health services over time, decisions about which services should be guaranteed to the population initially, and which should be added later, are based on the circumstances of each population and their health needs, public opinion, budget etc. (Watkins *et al.*, 2017).

Every health expenditure is a distributive choice with opportunity costs (of what could be gained from an alternative use of resources).

FIGURE 2
The three dimensions to be considered on the path to UHC



Source: The World Health Report (WHO, 2010).

Therefore, these choices must consider scientific evidence and the policy objectives of reducing health inequalities, giving preference to the worst-off, and maximizing efficiency in public spending by prioritizing treatments that bring large health gains at low cost (Ottersen *et al.*, 2014; Jamison *et al.*, 2013).

Systems reluctant to make such choices about priorities will end up spending a lot on expensive treatments that produce limited health benefits, probably at the expense of interventions that can have a major impact at population level at a proportionally low cost (Rumbold *et al.*, 2017). It is consistent with the goal of achieving UHC that countries begin their packages seeking sustainable and effective universal access to this second group of interventions (if they have not already done so) and progressively expand their coverage to include treatments in the first group. However, it would be unfair and counterproductive if the order of priorities was reversed (Ottersen *et al.*, 2014).

The identification of packages also brings transparency by making explicit the choices made by health systems. Users will know what their health care system have committed to providing. Transparency also allows accountability over what and how decisions are made and over spending plans and variations in the provision of services within a system. This all facilitates rights claims and reduces risks of favoritism, arbitrariness, corruption and discrimination in access.

The argument that explicit packages would violate SUS principles fails to acknowledge that Law 8.080/90, the SUS basic law, clarifies that the duty to providing "comprehensive care" is limited to the pro-

vision of drugs and services selected in clinical protocols and drugs lists prepared by SUS itself. Such limitations do not violate the principles of universality and comprehensiveness; on the contrary, lists such as the Relação Nacional de Medicamentos Essenciais [National List of Essential Medicines, Rename] organize service provision, make public what the SUS should offer to the population, and promote access and the rational use of health services. Therefore, delimiting the services offered is neither theoretically nor empirically incompatible with universal health systems.

UHC and the right to health

Alongside the criticisms of UHC already discussed, there is also an argument that UHC contradicts the idea of health as a human right (Castillo *et al.*, 2017). This stems from the idea that the right to health, unlike UHC, presupposes the existence of a universal system along the lines of the SUS; recognizes the right to access, rather than mere coverage; and guarantees the provision of services according to the needs of patients, and not those defined by limited service packages (Laurell, 2016).

The argument that UHC runs counter to the human right to health is surprising, given that UHC publications closely link it to the right to health. UN General Assembly Resolutions 67/81 (2012) and 72/28 (2017), which propose and advocate UHC, affirm "the right of every human being to enjoy the highest attainable level of physical and mental health", which is a direct reference to Article no. 12 of the United Nations Convention on Economic, Social and Cultural Rights (Chapman, 2016). The most recent UN Sustainable Development Goals report emphasizes access to health care services as a fundamental right (UN, 2018).

The WHO states that UHC "is a practical expression of the concern for health equity and the right to health" (WHO, 2012; Ooms *et al.*, 2014) and that "to support the goal of universal health coverage is [...] honouring everyone's right to health" (WHO, 2013). Tedros Ghebreyesus, Director-General of the WHO, is emphatic: UHC is a fundamental right (Ghebreyesus, 2017). The same statement was made in a World Bank report (The World Bank, 2015). There is also a vast literature on the proximity and overlap between UHC and the right to health. Although protecting the right to health may require more than UHC, it is unlikely that this right will be realized without removing financial barriers to universal access to health services (Chapman, 2016; Gostin *et al.*, 2019a; Yamin; Maleche, 2017; Ooms *et al.*, 2013). Furthermore, the recognition of the right to health in legislation has been defended as an important instrument for achieving UHC (Gostin *et al.*, 2019b).

The perceived opposition between UHC and the right to health is the result of a misunderstanding not only of UHC, but also of the right to health itself. General Comment no. 14 of the UN Commission for Economic, Social and Cultural Rights (UN/CESCR, 2000) includes under the right to health availability and access without discrimination to affordable, quality health goods and services. This document also clarifies that, due to the scarcity of resources, health is a right subject to "progressive realization" and recommends that countries seek to identify the most cost-effective ways of using these resources in order to "not disproportionately favour expensive curative health services which are often accessible only to a small, privileged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population". Therefore, UHC and the right to health in international law are very close in substance and language.

It could be argued that, although the UHC is compatible with the international right to health, it goes against the Brazilian Constitution, which recognizes the right to health based on a universal health system. However, as already discussed, the SUS model of universal health system is compatible with priority-setting. Although there are judicial interpretations that see the right to health as absolute and unlimited (Wang, 2013), the simple reading of Article no. 196 of the Federal Constitution shows that the principle of universality guarantees universal and equal access to health actions and services, but does not give SUS the duty to provide any and all treatment. The actions and services that should be provided by SUS are defined by infraconstitutional legislation (like Rename). Moreover, when establishing the principle of comprehensive and integrated care (Art. 198, II), the Constitution determines priority for preventive measures, explicitly recognizing the gradual realization of this right and the need to establish priorities.

CONCLUSION

There is no antagonism between UHC, the right to health and a universal health system. If this misconception persists, the public health scholarship in Brazil will deprive itself of the opportunity to participate in constructive debates around UHC that discuss, for example, the advantages and disadvantages of different types of health system for guaranteeing effective access, universality and protection from catastrophic expenditure; metrics, standards and methodologies for assessing and comparing the performance of different health systems; decision-making processes for accruing technical knowledge and social participation in decision-making; right-to-health and accountability mechanisms; and distributive justice in the funding of health care and in selecting health priorities.

This is a global dialogue to which Brazilian public health scholar have much to contribute, with its accumulated expertise after decades of constructing the SUS. It is also a dialogue that can help it face a scenario of underfunding of the SUS coupled with a huge increase in the price of private health insurance, which will force more and more people to choose between not receiving services or incurring catastrophic costs. This is exactly what a universal system, the right to health and UHC seek to avoid.[3]

[3] Translated into English by Matthew Richmond. [E.N.]

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