The right to health as the basis for universal access to essential medicines

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The right to health as the basis for universal health coverage: A cross-national analysis of national medicines policies of 71 countries

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Abstract

Persistent barriers to universal access to medicines are limited social protection in the event of illness, inadequate financing for essential medicines, frequent stock-outs in the public sector, and high prices in the private sector. We argue that greater coherence between human rights law, a national medicines policy (NMP), and universal health coverage schemes can address these barriers. We present a cross-national content analysis of NMPs from 71 countries published between 1990-2016. The World Health Organization's (WHO) 2001 NMP guidelines and all NMPs were assessed on 12 principles, linking a health systems approach to essential medicines with international human rights law for medicines affordability and financing for vulnerable groups. Of the principles studied, NMPs most frequently have measures for medicines selection and efficient spending/cost-effectiveness. Four principles (legal right to health; government financing; efficient spending; and financial protection of vulnerable populations) are significantly stronger in NMPs published after 2004 than before. Six principles have remained weak or absent: pooling user contributions, international cooperation, and four principles for good governance. Overall, South Africa (1996), Indonesia and South Sudan (2006), Philippines (2011), Malaysia (2012), Somalia (2013), Afghanistan (2014), and Uganda (2015) include the most principles. We conclude that WHO's 2001 NMP guidelines may have instructed thelanguage and content in subsequent NMPs. WHO and national policy makers can use the practical examples identified in our study to further align NMPs with human rights law and with target 3.8 for universal access to essential medicines in the Sustainable Development Goals.

Introduction

Universal access to essential medicines is an important component of the right to health and the Sustainable Development Goals (SDGs). Essential medicines are those required to meet the priority health care needs of a population. (1) Realising universal access to medicines requires a coherent approach to medicines as essential public goods. (2)

The World Health Organization (WHO) advocates for the adoption of a national medicines policy (NMP) as a commitment to a goal and a guide to action. WHO's 2001 guidelines to Develop and implement a national drug policy elucidate the key components of a NMP. (3) NMPs should be based on universal principles, involve a range of national stakeholders, and be tailored to the local context. (3,4) The first NMPs were predominantly adopted by low-income countries, and only since 2007 have many high-income countries followed. (4,5) By 2015, over 90% of low- and middle-income countries had published a NMP. (5,6) Adopting a NMP has been associated with the provision of essential medicines free at the point of care and better quality use of medicines, particularly in low- and middle-income countries. (7) However, in practice essential medicines remain inaccessible to many, especially vulnerable populations.

Barriers to universal access

Most studies frame medicines as a single 'input' or commodity to be supplied in the health system. (2) This view leads to fragmented policies and interventions that fail to address the system-wide constraints and consequently have a limited effect on medicines access for vulnerable groups. (2) Moreover, public policy in many countries does not consistently recognise essential medicines as essential public goods, nor is medicines accessibility seen as part of the progressive realisation of the right to health. (8) This failure, among others, may be linked to stagnating public financing for medicines, insufficient financial protection for patients, high medicines prices, and a general indifference towards medicines inequities. (2,5,6,9,10) In response to these challenges, WHO promotes its policies for essential medicines and health systems as tools to design and assess national responses for equitable and sustainable access to medicines. (1,3,11,12)

We assert that greater coherence is needed between NMPs' goals and strategies, the wider health system including universal health coverage (UHC), and human rights. We propose that embedding the salient aspects of a health systems perspective on essential medicines, with human rights law in NMPs can improve such policy coherence. We

hypothesise that our approach can also create a supportive environment for medicines affordability and financing for vulnerable groups.

The right to health emanates from international treaties, most notably the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR), which is ratified by 165 States. (13) These governments therefore bear the irrevocable duty to protect and promote the right to health. General Comment No. 14 (2000), an authoritative interpretation of the right to health by the UN Committee on Economic, Social and Cultural Rights, establishes that governments have the 'core obligation' to provide essential medicines and to establish a national health strategy and plan of action. (14) Given that a NMP is a country-wide strategy for the pharmaceutical sector for the provision of essential medicines, State parties can be understood as having a legal obligation to establish and implement a NMP or similar policy. The right to health establishes universal minimum entitlements to essential medicines for all, a set of State duties and guiding principles for government action (i.e. transparency and participation), and mechanisms for rights enforcement and redress.

Gaps in existing evidence

Despite the breadth of WHO's 2001 guidelines, little evidence exists about integrating essential medicines components and right to health commitments in existing NMPs. (3) The largest cross-national comparison of NMPs examines their effectiveness and uptake in 64 mostly low- and middle-income countries using national indicators for quality use of medicines. (7) Other analyses are single-country or regional studies comparing NMPs against WHO's essential medicines policies; however, these studies preclude large-scale cross-national comparison. (15–17) Previous research has not assessed the presence of right to health principles in NMPs.

Until recently there was no updated online repository of NMPs, which are generally published in English or the national language, and are available in hard copy or on local websites. Existing policy studies therefore mostly relied on governments' self-reports in the WHO Pharmaceutical Policy questionnaires of having a NMP or of its contents with binary (yes/no) answers. (7,16) In 2016, the Lancet Commission on Essential Medicines Policies undertook a first systematic search for all NMPs and deposited them in the WHO Essential Medicines Portal, which now provides easy access to these primary sources. (5)

Our chapter presents a first cross-national content analysis of essential medicines and right to health principles for access to medicines in 71

NMPs. Our comparison of NMPs also identifies some examples of strong text in support of universal access to medicines. These examples can inform policy makers who are developing and revising NMPs in the era of UHC and a strengthened right to health.

Materials and methods

Data collection

Between January to October 2015 we conducted a systematic search of all NMPs mentioned in academic literature, published in online repositories and on government websites, and further expanded through a global call through the E-DRUG online network. We included one official NMP per country. We excluded draft, incomplete, and unclear medicine policy documents, and policies addressing a specific component (i.e. intellectual property management), and documents in other languages besides English, Dutch, French, or Spanish. This method, previously reported in Wirtz et al., yielded 67 full text NMPs. (5) Between January 2017 to March 2018 we received an additional 13 full text NMPs that met the inclusion criteria.

We recorded the year of the country's most recent official NMP and its World Bank income category in the year of publication.

Policy checklist

We developed an assessment tool (called a policy checklist) by extracting the relevant principles for medicines affordability and financing from WHO's policies for essential medicines and international human rights law. (1,3,11,14,18–20) These human rights documents were chosen because they list the provision of essential medicines as a core obligation or elaborate on the nature of State duties.

The policy checklist identifies 12 specific attributes of policy text for access to medicines and categorises their strength on a 3-point scale (see Table 1). Two authors (KP and NVA) identified the 12 principles by first selecting a short list of concepts related to medicines affordability and financing from the above documents.

Through multiple, iterative rounds, two authors (KP and NVA) independently piloted the short list on three NMPs and devised a 3-point coding matrix. After each round we revised the principles and coding matrix through consensus. The resulting framework was reviewed by three experts on the right to health and pharmaceutical policy (BT, HVH, EtH) for applicability to NMPs and accuracy of the definitions.

Data analysis

Two authors (KP, NVA) worked with one half of the NMPs each to extract the relevant text (through keyword and manual search) and code it on a three-point scale (i.e. strong, weak, or absent text). Generally, strong text includes a clear State commitment to a principle and an action (i.e. to adhere to the concept of essential medicines and introduce a national selection committee) and where possible related to medicines affordability and financing. Weak text includes vague commitments. All codes and source text were independently reviewed (by both KP and NVA) who discussed inconsistencies and jointly agreed on the final codes.

We report the frequency of each principle in NMPs and describe the different approaches in different countries.

We hypothesised that the content of WHO's 2001 NMP guidelines would inform the content of subsequent NMPs. Therefore we divided NMPs between those adopted in or before 2003 (n=32) and those adopted in or after 2004 (n=39). Associations were determined in SPSS version 25 using Pearson's Chi-squared statistic with significance set at $p<0.05$.

Results

Of the 80 full text NMPs we retrieved, nine were excluded due to language restrictions or incompleteness. We included 71 NMPs published between 1990 and 2016. Our sample has a higher proportion of NMPs published before 2004 (≤2003 n=32/47 vs. ≥2004 n=39/88) and by low income countries (n=35/46) than wealthier nations (n=35/132).

The essential medicines and human rights principles included in each NMP are presented in Table 2. No NMP includes all of the 12 principles. NMPs with examples of innovative ideas are listed in Table 3 and the full text of these examples is available in Annex 1 to this thesis. The following sub-sections highlight the most relevant descriptive data for each principle.

Descriptive analysis

1. Right to health

Eleven NMPs frame access to medicines as part of the right to health (Congo 2004, Bhutan 2007, Kenya 2008, Colombia 2012, El Salvador 2011-2014, Kyrgyzstan 2014, Uganda 2015, Philippines 2011-2016, Rwanda 2016) and/or a right that governments must ensure (South Sudan 2006, Seychelles 2009). Kenya (2008) references the ICESCR and Colombia (2012) cites General Comment No. 14.

2. State obligation

Access to medicines as a State obligation is mentioned in Syria (1992), Tajikistan (2003), Iran (2004), Indonesia and South Sudan (2006), El Salvador (2011-2014), Kyrgyzstan (2014), and the Philippines (2011-2016). Uganda (2015) requires the government to progressively realise UHC with essential services. Four NMPs (Congo 2004, Maldives 2007, Suriname 2005-2008, Timor Leste 2010) frame the government as being responsible for continuous medicines availability at an affordable price. The State must ensure the availability of medicines for all in need (South Africa 1996). Bhutan (2007) and Sudan (2005-2009) require the State to establish mechanisms to guarantee access for all to the medicines they need at an affordable price.

3. Transparency

Eighteen NMPs mention the principle of transparency in relation to medicines prices, cost, or affordability. Notable examples reinforce the transparency of medicines selection and procurement (Malaysia 2012), funding decisions (New Zealand 2007), pricing (Philippines 2011-2016), price information sharing including with the public (Philippines, Malaysia) and through a price database (Malaysia).

4. Participation and consultation

South Africa (1996) and New Zealand (2007) include public participation in matters of medicines pricing and affordability.

5. Monitoring and evaluation

Monitoring medicines prices serves to compare and widen tenders (Oman 2000), as a benchmark for setting domestic prices (Iran 2004), contain price increases (Malaysia 2012), to monitor affordability (South Sudan 2006), cost-efficiency and acceptability (Afghanistan 2014), or to determine the effects of international trade agreements on domestic access to medicines (Nigeria 2005). Monitoring is done by the Pricing Committee (Somalia 2013) or through a database (South Africa 1996) or an electronic essential medicines monitoring system (Philippines 2011-2016). Uganda (2015) frames monitoring progress towards equity and efficiency as part of the progressive realisation of the right to health. Tajikistan (2003) presents a robust list of indicators and Barbados (1999) adopts the indicators of the Harvard Drug Policy Research Group and Management Sciences for Health.

6. Accountability

No NMP describes accountability in relation to medicines affordability or financing. The general principle of accountability is applied to medicines procurement (Pakistan 1997, Bhutan 2007), distribution (Botswana 2002), and financial management (Seychelles 2009, Swaziland 2011). Specific accountability mechanisms for general medicines issues are recognised in Kenya (2008), Malaysia (2012), and the Philippines (2011-2016).

7. Medicines selection

Three NMPs indicate that the national essential medicines list (EML) serves as a basis for UHC (Uganda 2015) or reimbursement (Namibia 1998, Philippines 2011-2016). Frequent references are to the selection procedure (i.e. committee composition, periodicity of list, n=40), the selection criteria (n=27), or to the concept of essential medicines and/or the WHO Model List of Essential Medicines (n=20). Less frequent was an explanation of the use or the purpose of an EML within the national health system (n=15). Comprehensive NMPs that address multiple aspects of the selection of essential medicines are South Africa (1996), Pakistan (1997), Namibia (1998), Oman (2000), Nigeria and Iraq (2005), Maldives (2007), Malaysia (2012), Somalia (2013), and El Salvador (2011-2014).

8. Government financing

Frequent references to government financing are for the provision of sufficient or adequate funding (n=14) and to base medicines procurement and provision on objective health needs (n=13). Less frequent is the duty of governments to dedicate funding to priority populations, priority diseases, or essential medicines (n=7), to increase funding for medicines (n=6) or to find alternate funding sources (n=4).

Only Guinea (1994) and Indonesia (2006) set a quantitative threshold for government financing. In Guinea, the government spending target is US$ 0.25/inhabitant/year to finance 'social medicines' such as vaccines, anti-leprosy medicines and tuberculosis medicines. In Indonesia, a financing target must be set considering WHO's then recommended minimum allocation of US$ 2.00/capita.

9. Pooling user contributions

No NMP includes the principle of universal financial protection for users nor the compulsory pre-payment of contributions (usually through health insurance). The most comprehensive language is from South

Africa (1996), Eritrea (2010) and Somalia (2013), which provide for free or low-cost access to medicines in primary care, and user contributions to finance medicines in secondary and tertiary care, with exceptions for people unable to pay. Botswana (2002) and Fiji (2013) adopt these principles as well, but without mentioning specific levels of care. A long-term objective in some NMPs was to develop health insurance and medicines reimbursement, e.g. in Namibia (1998), Tajikistan (2003), and Sri Lanka (2006).

10. International assistance and technical cooperation

Ten NMPs describe assistance from the international community to promote the affordability of medicines. Assistance takes the form of technical cooperation and partnership for medicines accessibility (Malaysia 2012); bilateral and multilateral aid for essential medicines programmes (Gabon 1999, Democratic Republic of Congo 2002, Congo 2004); the financing for the public sector (Ghana 2004); mobilising resources for new essential medicines (Afghanistan 2014); reference pricing policies and price information exchange (Ecuador 2007); the negotiation of prices at sub-regional level (ANDEAN) and the exchange of information to prevent monopolistic practices (Peru 2004); to establish a donor coordination mechanism to document the finances used in procurement (Swaziland 2011). Colombia (2012) calls for the development of an interagency agenda for 'health diplomacy and access to medicines' that would include a National Health Technology Assessment to exchange methods, information, and capacities with national and international networks of experts.

11. Efficient spending

Many NMPs describe various policy measures to achieve generic promotion (n=37), pricing policies (n=30), the use of flexibilities to the Agreement on Trade-Related Aspects of Intellectual Property (TRIPS) and other measures to manage intellectual property (n=21), tax exemptions (n=16), pooled procurement (n=8), price transparency (n=7), and price negotiation (n=7). NMPs that apply multiple, complementary policy measures are South Africa (1996), Ghana and Iran (2004), Nigeria (2005), Indonesia and South Sudan (2006), Ecuador (2007), the Seychelles (2009), Cambodia (2010), El Salvador (2011-2014), Jordan (2014), and the Philippines (2011-2016).

12. Protection for the poor and vulnerable

Eighteen NMPs refer to medicines affordability or financing for specific populations such as children, people in remote or mountainous locations, ethnic groups, women, the disabled, or people with 'priority

diseases' defined as tuberculosis, HIV, or malaria. Nine NMPs refer to medicines provision for general 'vulnerable' groups.

Trend analysis

Compared to WHO's 1988 guidelines, the 2001 guidelines introduce the first strong commitments to individual rights, transparency, and measures for efficiency and cost-effectiveness, for pooling user contributions, for international cooperation, and for financial protection of the poor and vulnerable. Measures for medicines selection and government financing are strong in both WHO's 1988 and 2001 guidelines.

Several trends are visible between NMPs published before or after 2004, including strong commitments to individual rights (≤2003: n=0/32 vs. ≥2004: n=13/39, p=0.000), measures for government financed-medicines (6/32 vs 18/39, p=0.015), for efficiency and cost-effectiveness (14/32 vs 29/39, p=0.009), and for financial protection of the poor and vulnerable (4/32 vs 13/39, p=0.041).

Discussion

This paper presents a cross-national comparison of the most recent NMPs from 71 countries, published between 1990-2016, using a 12-point checklist for universal access to medicines. The selection of essential medicines and their cost-effectiveness are the most frequent policy measures in our sample of NMPs. Good governance principles (transparency, participation, monitoring, or accountability for medicines affordability and financing), and measures to pool user contributions and to seek international cooperation remain weak or absent. An individual right to health and measures for the government financing of essential medicines, cost-effective spending, and the financial protection of vulnerable groups are significantly stronger in NMPs published after 2004 than in those published before. NMPs with the strongest commitments to essential medicines and human rights principles are from South Africa (1996), Indonesia and South Sudan (2006), Malaysia (2012), Somalia (2013), Afghanistan (2014), Uganda (2015), and the Philippines (2011-2016).

Historical trends

Our findings suggest that some aspects of WHO's 2001 guidelines were instructive and impactful on national pharmaceutical policy processes. Strong principles introduced in WHO's 2001 guidelines are significantly more frequent in NMPs adopted in 2004 or later (i.e. an individual right to health, measures for cost-effective spending, and the financial protection of vulnerable groups). Transparency is significantly more

common (although weakly and not always in relation to medicines affordability and financing) in NMPs adopted in 2004 or later. Other strong principles in WHO's 2001 guidelines are infrequent in NMPs adopted at all time points (i.e. measures to pool user contributions and to seek international cooperation).

We cannot draw firm conclusions about the causal relation between WHO's 2001 guidelines on NMP content, and subsequent policies. We examined only the most recent NMP per country and cannot discount the possibility that certain countries already embraced the 12 principles in previous NMPs. Paired examples are rare: even our most up-to-date collection of all available NMPs only has the full text of NMPs before and after 2004 from four countries (Afghanistan, Colombia, Kenya, Uganda). The example of Kenya shows that legal rights or obligations appear in its 2008 NMP and not in its 1994 NMP. Conversely, both of Colombia's 2003 and 2012 NMPs advocate for medicines as social goods, articulate health as a fundamental right, and promote measures to control medicines pricing.

Implications for national pharmaceutical policy

The innovative ideas and example texts identified in our chapter (Table 3 and Annex 1 of this thesis) form the basis of a balanced commitment to medicines affordability and financing in NMPs. NMPs should address each of the 12 principles to balance the government's duties as the primary funder of public sector pharmaceuticals, as the coordinator of all revenues (including user contributions and international funding), and as the steward of medicines selection, procurement and pricing.

Implications for WHO policy

If NMPs are to promote health systems strengthening for UHC and the right to health, then our study suggests that WHO's 2001 guidelines should include clear references to these principles. Aligning WHO's 2001 guidelines with WHO's policies for essential medicines and human rights law will raise Member States' awareness of the importance of human rights, their legal obligations, and the policy measures to implement these duties in practice. Moreover, official WHO guidance on how to address UHC and embed the right to health in NMP text, with specific examples, can support ongoing national reform or trigger other initiatives for universal access to essential medicines. Ultimately, enhanced legal commitments and political can catalyse inclusive progress towards universal access to essential medicines and the SDG for health.

How should WHO's guidelines be revised? WHO's NMP guidelines should address critical gaps by explicitly referencing the State duty to provide essential medicines, the participation of beneficiaries in medicines policy, and the creation of (non-judicial) accountability and redress mechanisms. If appropriately implemented, enhanced accountability and redress mechanisms, such as easy-to-access complaint and grievance procedures for patients, have the potential to swiftly remove access barriers. (21) These mechanisms can also stem the wave of spurious human-rights based litigation rising in some Latin American countries. (22–24)

Implications for research

Future research should investigate whether and how the commitments in NMPs are implemented in government practice. More investigation is needed to determine how effective rights-based medicines policies are at improving medicines affordability and equitable access for patients, and what the facilitators and barriers to implementation are.

Strengths and limitations

Although our NMPs are sourced from the most comprehensive collection to date, our sample has more NMPs published before 2004, and from low income countries. Underrepresentation of some countries may be caused by governments self-reporting 'yes' in the WHO Pharmaceutical Sector questionnaire despite not having an official NMP (i.e. Mexico) or having a law similar to a NMP (i.e. Morocco). In other cases the full text of official NMPs are unretrievable online.

We mitigated the risk of overlooking relevant content in our analysis by working with researchers fluent in the original language of the NMP and trained on the structure, standard terminology, and definitions used in the WHO guidelines and our checklist.

Conclusion

Our study demonstrates how a human rights-based approach to access to essential medicines within UHC schemes is integrated into 71 NMPs, using a 12-point checklist focusing on medicines affordability and financing for vulnerable groups. Specific examples of how essential medicines and human rights principles are phrased in NMPs can be used by WHO and national policy makers to further align the goals and strategies of the national pharmaceutical sector with human rights law and the SDG targets for universal access to essential medicines.

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Table 1. Policy checklist for access to medicines in national law and policy.

Checklist	Human rights principle	WHO essential medicines policy	Coding matrix
Legal rights and obligations			
1. Right to health	Right to the highest attainable standard of health	Human rights are a 'value'. (2)	**Black** = Clear endorsement of the right to health of all; may be related to medicines. **Grey** = Vague reference to the right to health or rights of patients, consumers, or users. **White** = No entitlement.
2. State obligation to provide essential medicines	Core obligation to provide essential medicines defined by WHO		**Black** = Absolute State obligation to ensure/guarantee access to (essential) medicines for all or to take measures so everyone can access the medicines they need. **Grey** = Vague State duty to provide healthcare or implement the NMP, or a shared duty between the State and others to provide medicines. **White** = No obligations .
Good governance			
3. Transparency	Transparency	Information to assess service access and coverage, and publicly available price information for medicines. (1,3) Also an aspect of good governance for medicines. (12)	**Black** = Transparency measures in relation to medicines affordability and financing. **Grey** = Transparency measures in general. **White** = No transparency measures.

4. Participation & consultation	Participation	Collaboration and accountability of all health systems actors, and stakeholder consultation. (1,3) Also vaguely referenced in good governance for medicines. (12)	**Black** = Participation and consultation measures in relation to medicines affordability and financing. **Grey** = Participation and consultation measures in general. **White** = No participation and consultation measures.
5. Monitoring & evaluation	Monitoring	Achieved through explicit government commitment, indicator-based surveys, and independent impact evaluation. (1,3) Also a component of good governance for medicines. (12)	**Black** = Monitoring and evaluation measures for medicines affordability and financing. **Grey** = Monitoring and evaluation measures in general. **White** = No monitoring or evaluation measures.
6. Accountability & redress	Accountability	Accountability of all health systems actors. (1) Also a component of good governance for medicines. (12)	**Black** = Accountability and redress measures if an individual is unable to access the medicine he/she requires. **Grey** = Accountability in general is acknowledged. **White** = No recognition of accountability nor redress.

Technical implementation			
7. Selection of essential medicines	(Assured) quality of health services (of the AAAQ)	Includes the essential drugs concept, procedures to define and update the national list(s) of essential drugs, explicit, evidence-based criteria that includes cost-effectiveness, and selection mechanisms. (3, 11)	**Black** = Comprehensive approach (principle of medicines selection AND mechanisms for selection) **Grey** = Vague principle OR a single policy measure without a comprehensive approach to essential medicines. **White** = No recognition of essential medicines.
8. Government financing	Duty to adopt appropriate legislative, administrative, budgetary and other measures to a maximum of its available resources. Core obligation to provide essential medicines as defined by WHO	Requires adequate funding and mobilising all available public resources and increase funding for priority diseases, and the vulnerable. (1,3,11)	**Black** = Clear State obligation to finance (essential) medicines and a specific policy measure. **Grey** = Vague State commitment (i.e. to increase budget for medicines) or shared responsibility of State and others. **White** = No government financing.
9. Pool user contributions		Medicines reimbursement with user charges is a (temporary) financing option. (1,11)	**Black** = Provision of primary care medicines free-of-charge/for nominal fee, co-payments for other medicines, and exceptions for those who can not pay. **Grey** = Principle of cost recovery, reimbursement, or joint responsibility of State and users to finance medicines. **White** = No concept of nor criteria for user contributions.

10. International assistance and technical cooperation	Duty to seek international assistance and technical cooperation	Includes the possibility of using development loans for medicines financing. (11)	**Black** = Financial aid or/and technical assistance from the international community (not only the private sector). **Grey** = Reference to international cooperation for health/UHC. **White** = No means for international cooperation.
11. Efficient and cost-effective spending	Duty for the efficient use of available resources	Includes the efficient use of resources and affordable pricing through: price control; a pricing policy for all medicines; competition through generic policies and substitution; good procurement practices; price negotiation and information; and TRIPs-compliant measures such as compulsory licensing and parallel imports. (1,3,11)	**Black** = Principle of cost-effectiveness / efficiency, AND one or more mechanisms in relation to medicines. **Grey** = Either the principle OR mechanisms for cost-effectiveness/efficiency, but not both. More generally about health care/UHC. **White** = No principle and mechanisms for spending.
	Duty to take appropriate steps to ensure that the private business sector is aware of, and consider the importance of, the right to health in pursuing their activities.		

	Duty to prevent unreasonably high costs for access to essential medicines from undermining the rights of large segments of the population to health.		
	Duty to seek low-cost policy options		
12. Financial protection of vulnerable groups	Duty towards non-discrimination and attention to the vulnerable	Increase government funding for poor and vulnerable groups and reduce the risk of catastrophic health spending. (1,11)	**Black** = Clear State duty to finance UHC package / essential medicines for all vulnerable people. **Grey** = Vague State duty (i.e. exemption for some vulnerable people but unclear whether State finances their medicines) **White** = No financial coverage of the poor.

Abbreviations used in this table: WHO=World Health Organization; TRIPs=Trade Related Aspects of Intellectual Property; AAAQ=Availability, Accessibility, Acceptability, and Quality as elements of health services under the right to health.

Table 2. Overview of the 12 principles for access to medicines in national medicines policies from 71 countries.

NMP publisher	Date of publication	1. Right to health	2. State obligation	3. Transparency	4. Participation & consultation	5. Monitoring & evaluation	6. Accountability & redress	7. Selection of essential medicines	8. Government financing	9. Pool user contributions	10. International assistance	11. Efficient & cost-effective spending	12. Protection of vulnerable groups
WHO	1988												
WHO	2001												
Afghanistan	2014												
Albania	1991												
Andorra	1999												
Australia	2000												
Bangladesh	2005												
Barbados	1999												
Benin	2008												
Bhutan	2007												
Bolivia	2003												
Botswana	2002												

Burkina Faso 1996
Cambodia 2010
Central African Republic 1995
Chad 1998
Chile 1996
Colombia 2012
Comoros 1997
Congo 2004
Cote d'Ivoire 2009
Democratic Republic of Congo 2002
Ecuador 2007
El Salvador 2011-2014
Eritrea 2010
Ethiopia 1993
Fiji 2013
Finland 2011
Gabon 1999
Gambia 1994

NMP publisher	Date of publication	1. Right to health	2. State obligation	3. Transparency	4. Participation & consultation	5. Monitoring & evaluation	6. Accountability & redress	7. Selection of essential medicines	8. Government financing	9. Pool user contributions	10. International assistance	11. Efficient & cost-effective spending	12. Protection of vulnerable groups
Ghana	2004												
Guinea	1994												
Haiti	2014												
Indonesia	2006												
Iran	2004												
Iraq	2005												
Jordan	2014												
Kenya	2008												
Kyrgyzstan	2014												
Liberia	2001												
Malawi	1990-1995												
Malaysia	2012												
Maldives	2007												
Mali	2000												

Mauritania	2002
Namibia	1998
Nepal	1995
New Zealand	2007
Niger	1995
Nigeria	2005
Oman	2000
Pakistan	1997
Peru	2004
Philippines	2011-2016
Rwanda	2016
Senegal	2006
Seychelles	2009
Somalia	2013
South Africa	1996
South Sudan	2006
Sri Lanka	2006
Sudan	2005-2009
Suriname	2005-2008

NMP publisher	Date of publication	1. Right to health	2. State obligation	3. Transparency	4. Participation & consultation	5. Monitoring & evaluation	6. Accountability & redress	7. Selection of essential medicines	8. Government financing	9. Pool user contributions	10. International assistance	11. Efficient & cost-effective spending	12. Protection of vulnerable groups
Swaziland	2011												
Syria	1992												
Tajikistan	2003												
Tanzania	1991												
Timor-Leste	2010												
Togo	1997												
Trinidad and Tobago	1998												
Uganda	2015												
Vietnam	1996												
Zimbabwe	2011												

Legend: Black=Strong text, Grey=Weak text, White=No text.

Table 3. Innovative NMP text for access to medicines.

1. Right to health including essential medicines El Salvador (2011) - Southern Sudan (2006)
2. State obligation to provide pharmaceuticals Indonesia (2006) - Iran (2004) - Philippines (2011-2016) - Uganda (2015)
3. Transparency Iran (2004) - Philippines (2011-2016)
4. Participation and consultation New Zealand (2007)
5. Monitoring and evaluation Colombia (2012) - Philippines (2011-2016) - Tajikistan (2003)
6. Accountability and redress Afghanistan (2014) - Kenya (2008) - Malaysia (2012)
7. Selection of essential medicines Philippines (2011) - South Africa (1996)
8. Government financing for essential medicines Afghanistan (2014) - Nigeria (2005)
9. Pooling user contributions Eritrea (2010)
10. International assistance and cooperation Ecuador (2007) - Ghana (2004)
11. Efficient and cost-effective spending on essential medicines Ecuador (2007)
12. Financial protection of the poor and vulnerable Jordan (2014) - Philippines (2011-2016) - Timor Leste (2010)

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