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Access to health care as a human right in international policy: critical reflections and contemporary challenges

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Abstract *Using the United Nations (UN) and its subordinate body, the World Health Organization (WHO), as a frame of reference, this article explores access to healthcare as a human right in international intergovernmental policies. First, we look at how the theme of health is treated within the UN, focusing on the concept of global health. We then discuss the concept of global health from a human rights perspective and go on to outline the debate surrounding universal coverage versus universal access as a human right, addressing some important ethical questions. Thereafter, we discuss universal coverage versus universal access using the critical and constructivist theories of international relations as a frame of reference. Finally, it is concluded that, faced with the persistence of huge global health inequalities, the WHO began to reshape itself, leaving behind the notion of health as a human right and imposing the challenge of reducing the wide gap that separates international intergovernmental laws from reality.*

Key words *Global health, Human rights, Bioethics, International agencies*

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Introduction

A wide array of organizations and authors have addressed the theme of human rights and health in international policy in recent years[1-4]. At the same time, comparative evaluations of health policies in different countries from a human rights perspective have become increasingly common through spaces such as fora, seminars, institutes, academic programs and think tanks[5]. Furthermore, a number of works have examined the health legislation of individual countries from a human rights perspective and the implications for the well-being of their citizens[6], including the position of economic blocs such as the European Union on this matter[7].

However, the relationship between human rights, health, and international policy has not been sufficiently explored from a perspective that transcends comparative and legal exercises deployed exclusively in the domestic sphere[8] to analyze the supra-national or transnational scope of such policy.

This article departs from a definition of international policy that is not circumscribed by the foreign policy of nation states, but rather determined by the multilateral bodies – and other exclusive non-state actors – that make up the supranational system that governs the modern international system, with particular reference to the most important supranational institution in terms of representativeness and historical relevance: the United Nations (UN)[9], and, consequently, its subordinate body, the World Health Organization (WHO). In other words, drawing on critical and constructivist theories of international relations and considering some important ethical questions, this article attempts to examine the right to health as a fundamental human right in intergovernmental international policy.

This article is divided into four sections. The first deals with how the theme of health is treated within the UN and the production of international policy by the WHO, focusing on the concept of global health, the main product of such policy in recent years. The second section discusses the concept of global health adopted by the WHO from a human rights perspective and outlines one of the most controversial debates therein: universal coverage versus universal access. The third section goes on to outline the main issues of this debate, addressing some important ethical questions. The fourth section discusses universal coverage versus universal access using the critical and constructivist theories of international relations as a frame of reference. Finally, we outline some of the challenges and possible scenarios.

Health inside the UN and the concept of global health

Health is an especially relevant issue within the UN, as evidenced by the health-related goals and objectives of this supranational body, most notably the core values of the Millennium Development Goals set out in the United Nations Millennium Declaration published in 2000[10], and, more recently, the Sustainable Development Goals[11]. Such is the importance of this issue within the UN and other international organizations that there is a specific academic area dedicated to the topic: global health.

In this respect, it is essential to mention the WHO, a special agency integrated into the UN System that plays a lead role in shaping the concept of global health. It is important to highlight that the doctrine of global health advocated by the WHO brings into play three of the elements explored by this article: health, human rights, and intergovernmental policy. One only needs to look at the WHO's constitution[12], signed on 22 July 1946, to understand the relationship between these three elements: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (Preamble).

This is further complemented by Fact sheet N° 323 December 2015[13], which explicitly considers health a human right when it states that "Achieving the right to health is closely related to that of other human rights, including the right to food, housing, work, education, non-discrimination, access to information, and participation", or when it admits that "Health policies and programmes have the ability to either promote or violate human rights, including the right to health, depending on the way they are designed or implemented".

It should be made clear, therefore, that the analysis presented here is limited to the concept of health as a human right laid down by international policy produced by the WHO and circumscribed by global health. As will be seen below, global health, framed within this relationship between human rights and health, has been the subject of various ethical and political discussions and debates[3].

Global health can be understood from different historical, theoretical and political perspec-

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tives, reason for which the literature has yet to arrive at a consensus as to its definition[14-16]. Koplan et al.[17], for example, define "global health" as "an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide". Marušič[16] underlines that, despite different understandings, the array of visions of global health share some common primary characteristics, including equality (in health status and access) and a global conceptualization (as opposed to an international or supranational perspective).

Fortes et al.[14] make the link between global health the historic process of economic and technological globalization and the emergence of global environmental problems and new migration flows. Kickbusch[15] touches on the latter perspective by highlighting the ethical facet of global health, which, conceptually, requires an understanding of the relationship between human health, the health of the planet, and wealth.

It is therefore important to underline the differences between the concepts of "international health" and "global health". According to Brown et al.[18], whereas international health refers to the relationships between governments with regard to policies and practices of public health, global health is normally associated with the more recent phenomenon of globalization and *implies consideration of the health needs of the people of the whole planet above the concerns of particular nations*. In other words, while international health focuses on cross-boundary health issues that threaten nations' interests, global health focuses on planetary issues concerning the health of humankind.

Finally, the consolidation of health as a global concern is also associated with the emergence of philanthropic trusts and foundations - which initially sprung up in the 1970s, further developing and strengthening their role at the beginning of the 2000s - to provide funding and assistance to combat "global" diseases. Such organizations include the Bill & Melinda Gates Foundation, Ford Foundation, the GAVI Alliance (formerly the Global Alliance for Vaccines and Immunization), the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank, as well as the century-old Rockefeller Foundation[19]. These organizations are umbilically linked to the major powers in the world's political economic ordering, and it would not be rash to affirm that they act according to the interests of these powers.

Global health and health as a human right

The theme of human rights – more specifically the right to health – is certainly one of the most controversial issues within the area of global health[20]; first, since improving health and ensuring equity in health to enable all people to achieve an acceptable standard of health is the central objective of this young area[17], and, second, because it inevitably involves costs and encompasses a range of issues related to the stark injustice and inequity faced by a significant portion of the world's population immersed in a neoliberal system that excludes millions of people[21].

It is evident, therefore, that acknowledging health as a human right in its constitution and various subsequent statements, guidelines, and reports has profound implications for the WHO on the international stage. Evans[22] views this as a challenge, fittingly pointing out that the right to health is one of a range of rights for which many states have accepted an obligation under international law. According to this author, the challenge stems from the fact that liberalism refuses to give this type of human right the same status as civil and political rights.

In the same vein, in an article analyzing the WHO Commission on Social Determinants of Health's goal of reducing health disparities from a human rights perspective, Schrecker et al.[23] clearly show that the right to health is potentially enforceable through national and international courts and propose lines of action: international litigation, state institutional channels for realizing the human right to health, and holding rich countries accountable for health injustice and inequalities.

These authors suggest that human rights, especially the right to health, can help advance toward global health equity. The enormous impact that human rights have on the area of global health is therefore evident here. This should be reiterated, not only because its existence is associated with significant costs of national health systems, but also because of the legal obligations vis-à-vis the international community.

Fox & Meyer[24] relate social determinants of health, which they call the "right to development", with the human right to health. What is most striking about their proposal is not the fact that they associate the human right to health with social determinants of health, but rather that they situate this right within the relative inequalities produced by the unjust and unequal globalized neoliberal economic system. These

authors affirm that the "right to development", working through the human right to health, can obligate states and the international community to support public health systems.

It should be highlighted that these authors[24] stress that a human rights-based approach to global health is central to restructuring international institutions and cooperation programs. They suggest that the approach should be applied in ways that hold those countries directly responsible accountable for the great injustices represented by health inequities, which are in large part a result of a globalized neoliberal system that impoverishes and disregards the rights to health, education, and work of millions of people. These authors affirm that this new human rights perspective allows countries the right to cooperation, rather than simply "cry for charity".

With regard to the ideas proffered by Fox & Meyer[24], it is important to touch on the Universal Declaration on Bioethics and Human Rights (UDHR)[25], for two reasons: first, because it is an international instrument that clearly associates health with human rights, especially the duty of states to ensure the highest attainable standard of health for their citizens regardless of economic conditions (articles 10 and 14, among others); and second, because international experts such as Gros-Espiell[26] affirm that, although the UDHR must be regarded as a non-binding instrument, *with all the consequences it entails … are mediated sources of law … which are of universal character, as an expression of the international community as a whole*.

As it can be seen, therefore, the list of authors who defend the enormous potential of health as a human right is rather long[27-29]. Although it is not the purpose of this article to provide an exhaustive analysis of this topic, it should be noted that the potential of this approach has yet to be fully exploited and huge health inequalities and injustice persist both within and across nations. In the next section, we therefore seek to address one of the debates that problematize this fact: "universal coverage versus universal access".

Finally, it is important to stress that this debate is especially important for a number of reasons: first, it touches directly on the concept of health as a human right laid out in international policy created by the WHO; second, it probably represents the most controversial topic in debate today in this area[20]; third, the Brazilian experience in shaping the Unified Health System (SUS) based on the idea of free and universal access to comprehensive health care is recognized worldwide[30] and is currently undergoing a sensitive political transition that could lead to the reform of the system geared towards the 'universal health coverage' paradigm through the propagation of affordable private health insurance plans[31].

Universal coverage versus universal access (right) and health as a human right

I regard universal health coverage as the single most powerful concept that public health has to offer. This phrase, proffered by the WHO Director-General, Margaret Chan[32], during the opening of the WHO/World Bank Ministerial Meeting on Universal Health Coverage (UHC) in February 2013, illustrates the driving force behind the current so-called "Universal Health Coverage" agenda. UHC was materialized through Resolution 58/33[33], and is decisively supported by a United Nations resolution adopted by the General Assembly at its 67th session entitled *Global Health and Foreign Policy*[34].

Although the concept of "universal coverage" (UHC) is used generically to refer to an array of topics and approaches in the realm of public health, it has developed around specific contingencies that reflect interests and objectives that are often contrary to what was intended when it is used inadvertently.

Basically, universal coverage is made up of systems of financing through "insurance policies" that cover a limited package of services provided by for-profit or nonprofit organizations. Kutzin[35] affirms that "s*trictly interpreted, UHC is a utopian ideal that no country can fully achieve*", shaped into different "processes" tailored to the specific characteristics of each country.

Stuckler et al.[36] add that the term "universal health care" is generally used to describe health policies in high-income countries, while "universal health coverage" is commonly applied to low and middle-income countries. This distinction is derived from the (aprioristic) understanding that in countries facing greater financial constraints it is only possible to achieve broad access to health care services (universal health care) by providing "coverage" through basic packages and services for the whole population (universal health coverage).

The WHO[37] defines UHC as the desired outcome whereby *all people who need health services (promotion, prevention, treatment, rehabilitation and palliation) receive them, without undue financial hardship*.

According to a WHO report published in 2010[38], funds for financing UHC may be made

up of a mix of inputs ranging from contributions made by health policyholders, through direct charging, income tax, or specific taxes on products that are harmful to our health; and, in the case of poorer countries, through international philanthropy and aid programs.

From an historical perspective, the concept of UHC dates back to the health system reforms of the 1980s captained by international financial institutions, especially the World Bank whose main concern was ensuring the "financial sustainability" and "efficiency" of health systems by reducing public spending and favoring an increase in private investment in health[39] and public-private partnerships[40]. This meant that the initial proposals for UHC were not designed by researchers, public officials or health organizations, but rather by economists and actors in the financial markets and international agencies, particularly the World Bank.

Noronha[41] highlights that the first reference made to the term "universal health coverage" by the WHO dates back to the World Health Report 2005[33], which *launches the semiotic transformation of the right to health and universal and equal access to health care into the concept of "universal coverage", indelibly associated with "financial risk protection" and the search for alternative mechanisms for health sector financing*.

Noronha points out that the abandonment of health as a fundamental human right in favor of the understanding of health as a basic service reflects an inversion of priorities in health policy making: the right to health no longer determines health-financing policy to accommodate the limitations imposed by the financing systems. In other words, UHC seeks to ensure the "health" of the economic and financial systems to the detriment of the "health" of human beings.

Thus, UHC is nothing more than a program to make states unaccountable and outsource health systems: rather than being understood as a universal human right, health is seen as a limited package of services available for people and groups, preferably facing financial hardship or impoverishment, "covered" by policies. The mantra of universal health coverage therefore conceals an idea that is exactly opposite to its real meaning: a nonuniversal, uncomprehensive, nonpublic, and nonfree health program.

It is therefore evident that the coverage proposed above has left behind the notion of health as a human right, since access to health care is subordinated not to the *humana conditio* of individuals, but rather the financial conditions necessary for achieving access, relating UHC to a basic package of services provided to more economically disadvantaged groups. The technical brief "Achieving Universal Health Coverage: Developing the Health Financing System"[42], as well as the reports "Health Systems Financing: The Path To Universal Coverage"[38] and "Research for Universal Health Coverage"[32] confirm this.

These documents explicitly state that access to health care depends directly on an individual's ability to pay, since he/she should avoid the financial risks that disease may incur[43]. Even more important, these documents clearly propose that national health systems should be safeguarded by private insurance companies that provide protection against the financial risk posed by the health of population.

It is therefore evident that the ways the WHO has found to overcome the challenges posed by health as a human right - a notion that the organization itself introduced - have gone against its own creation, detaching health from human rights and associating it with financial constraints. The WHO[44] has responded to criticisms that have arisen in this regard by claiming that universal coverage is a necessary initial step towards achieving this right, which some call "access".

The above, however, is problematic, since, not only is it clearly inconsistent, but also because the facts show (and demonstrated even before the implementation of this international policy in 2005) that coverage does not necessarily translate into a right or access to health. The major access problems faced by health care systems implemented based upon the same premises defended by the WHO in countries such as Columbia[45], Mexico[46], and Chile[47], to name but a few, demonstrate this.

As it can be seen, therefore, the debate surrounding universal coverage versus universal access is at the center of discussions regarding the notion of health as a human right in international policy created by the WHO. This is so because defending coverage and delegating it to private health insurance companies goes against that which is laid out in its own constitution. The following section addresses this fact in the light of critical and constructivist theories of international relations in order to explain its genesis and propose possible routes to overcoming this contradiction.

Universal coverage versus universal access in the light of critical and constructivist theories of international relations

As has been seen, health coverage, elected by the WHO to "ensure" access to health care for the millions of human beings whose rights are not respected, is problematic in itself. It is important to understand how this was made possible and the possible ways of overcoming this contradiction. With regard to the first question - "how" – the answer is practically unanimous: by obeying the logic of the market and neoliberal rationale, which regard health as a consumer good rather than a human right constituted from the moment of birth that should be enjoyed by all humankind[48].

Given that neoliberal logic is at odds with the idea of exclusive state action, it would be of little use here to examine this question in the light of theories that place almost exclusive emphasis on these actors. It is therefore important to draw on other approaches that are able to explain "how" coverage became the solution for achieving access to health care. In this respect, constructivist[49] and critical[50-51] theories of international relations can provide some important insights.

Constructivist theory vigorously contests the realist and liberal notion that states alone, through the exercise of power, define international policy. Contrary to this assumption, constructivism claims that it is the ideas, collective values, and changing identities that define the agenda[52]. In this respect, constructivists are mindful of the multiple levels of decision making and understanding within the tapestry of the modern international community, allowing one to understand that it was not the exclusive decision of states, but rather neoliberal economic logic, that led to the election of health coverage as the global paradigm.

The above is also important because the decisions and actions of the WHO cannot be explained solely by the power and existence of states. Indeed, international corporations, foundations and nongovernmental organizations (NGOs) often carried more weight than state actors. The key role played by the Rockefeller Foundation[19] in the election of universal coverage over universal access is a clear demonstration of this.

Critical theory helps to explain how material (particularly economic) circumstances have influenced decision making within the WHO, since it touches on an important variable related to the role played by the doctrine behind the policy in setting the global agenda. Furthermore, the method of historical structures proffered by Cox[50], a critical theorist, applied to the realm of social forces - and inspired by the state/civil society complex spoken of by Gramsci[53] – affords possible solutions (as will be explained below) to the problem of the commodification of health care.

In the same vein Kenny[54], in a recent article problematizing the biopolitical dimensions of global health, situates its emergence in the neoliberal metrics of the World Bank, which have led to the "economization" of life, defining the individual as a neoliberal *homo economicus*, whose life and health is disaggregated and limited by practices of self-investment, return on investment, and self-promotion.

Also along these same lines, Birn et al.[55] points to the neoliberal cooptation of global health over the last three decades. These authors raise an interesting and relevant question here: taking Latin America as their frame of reference, Birn et al.[55] suggest the need to create ways and means to strengthen the struggle against this cooptation, resisting and challenging the neoliberal health agenda towards achieving truly equitable global health based on a human rights perspective.

It is useful to examine this question in the light of theories that move away from an exclusive emphasis on state actors, not only to better understand how coverage has gained prominence over access, but also to gain an insight into the possible ways of overcoming the neoliberal logic, such as legitimizing the role of civil society organizations and other initiatives; something that is not possible under the exclusive state paradigm.

This is how London & Schneider [28] understand it when they call for the creation of a space to enable civil society to hold governments accountable for implementing the human right to health. In this sense, these authors suggest that the human rights paradigm can be useful in helping civil society organizations reclaim that which globalization has taken away from them, through what they call "state accountability".

Along the same lines, Friedman & Gostin[27] propose a four-part approach including civil society and community engagement to reclaim the right to health. The first part envisages national legal and policy reform incorporating equity, participation, and accountability in relation to the health sector. The second involves the use of legal strategies to advance the right to health, while the third encompasses community engagement, empowering communities to claim

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their right to health. Finally, the fourth part seeks to directly influence how the WHO works by proposing a new global health treaty called the Framework Convention on Global Health to help construct these four pillars.

Finally, acknowledging the important role civil society plays in reversing the commodification of health care, Špoljar[29] argues that there is a need for a critical reflection on human rights to differentiate between "politics for human rights" and "politics of human rights", whereby the latter is simply the instrumentalization of these rights used to disguise government initiatives that, far from fulfilling the right to health, seek to defend the conception of health as a tradable good.

Final considerations

The issue of health from a human rights perspective has been addressed within the UN, resulting in international policies that either reinforce or weaken the idea of health as a right. More than 65 years after the Universal Declaration of Human Rights[56], human rights in general, and the right to health in particular, seem to be diluted, raising questions about the current policies of the organization and its executive agencies, such as the WHO. On the one hand, the UDHR reaffirms the right to health as a form of resistance[25], while on the other, attention has shifted away from universal access toward universal coverage, which seems to undermine the notion of health as a right, revealing the current weaknesses of the UN in the face of intergovernmental actions and contributing to growing health inequalities.

The unacceptable global inequalities in health have widened with globalization: the activities of transnational agencies – that involve an array of public and private actors, including states, civil society and corporations - are permeated by different degrees of power and interests that can have nefarious side effects, thus playing a role in widening inequality[57].

Treating health as a universal human right means understanding its historical and political dimensions and real social impacts. It can be observed that, against the current backdrop of transformation, "global health" has emerged as part of wider historical and political processes in which the WHO, which played an unquestionably leading role in the realm of international health up to the end of the Twentieth Century, has lost its status, becoming an organization that is currently undergoing a crisis, facing budget shortfalls and subject to the growing influence of powerful transnational organizations[18].

As a survival strategy in response to this context of international political change, the WHO has begun to reshape itself[18]. Proof of this is the abovementioned debate surrounding universal health coverage within the WHO itself, which, by associating health with financial constraints, is undermining the notion of the right to health enshrined in the organization's constitution and various other statements, guidelines, and reports. As a result, the simple *humana conditio*, which ensures the human right to health from a biological point of view, does not appear to be sufficient to fulfill this right.

The arduous path to achieving the human right to health is marked by progress and setbacks. The persistence of huge global health inequalities that deny millions access to health care and dignified living conditions - rooted in global political and economic phenomena permeated by power asymmetries - reveals limited progress in the concretization of human rights. In the current scenario, the path taken by the WHO towards universal health coverage tends to relegate the right to health to a distant place by subordinating it to economic concerns. In this way, certain people and communities come to be categorized as "more human" than others. It is necessary to reinforce the discussions connected to health as a right for all in intergovernmental international policy and reduce the wide gap that separates such policies and laws from reality in order to ensure human rights, particularly the right to health.

Collaborations

CH Manchola was responsible for study conception and the drafting and final revision of this article. V Garrafa, TR Cunha, and F Hellmann participated in the drafting and final revision of this article.

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