Universal access to essential health care: propositions from public international law to implement essential health care in conjunction with universal social protection

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Health and social security: inseparable pillars of universal social protection

The crucial role of universal access to health care, the degree of attention it requires and the imperative to implement nationally defined sets of goods and services constituting essential health care, in conjunction with social protection provisions, may be argued succinctly in a series of propositions, which are advanced here[2].

The legal foundation of universal access to essential health care as a human right

Health appears in international public law since the beginnings of international jurisprudence. Firmly incorporated in the 1948 Universal Declaration of Human Rights in Article 25[3]:

> "*Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including […] medical care and necessary social services, and the right to security in the event of […] sickness, disability […]*",

this right was specified in the International Covenant on Economic, Social and Cultural Rights of 1966 as an aspiration in Article 12[4]:

> "*The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*",

and conclusively determined by the Committee on Economic, Social and Cultural Rights (CESCR) in the opening paragraph of its General Comment No. 14 in 2000[5]:

> "*Health is a fundamental human right indispensable for the exercise of other human rights*".

Importantly, the CESCR points out in General Comment No. 14 that:

"*…the reference in article 12.1 of the Covenant to "the highest attainable standard of physical and mental health" is not confined to the right to health care*" (see §4).

Acknowledging that:

"*… good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health*" (see §9),

the CESCR nevertheless

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[2] An earlier version of this statement was published in French as : "L'accès universel aux soins de santé : La sécurité sanitaire et la sécurité sociale sont indissociables, et constituent les deux piliers de la protection sociale universelle". *Revue Quart Monde* 2020/3 N°255: 14-18.
[3] UN General Assembly, 1948. *Universal Declaration of Human Rights*. Adopted by General Assembly Resolution 217 A(III) of 10 December 1948.
[4] UN General Assembly, 1966. *International Covenant on Economic, Social and Cultural Rights*. Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966. Entry into force 3 January 1976, in accordance with article 27.
[5] UN Committee on Economic, Social and Cultural Rights (CESCR), 2000. *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*. Adopted at the Twenty-second Session of the CESCR, 11 August 2000.

"*…interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health*" (see §11).

The right to health and right to social protection now inseparable

Since the Universal Declaration of Human Rights (1948), the rights to health and to social security have been addressed together. Established not only in Article 25, but also in Article 22[6]:

"*Everyone […] has the right to social security*",

the right to social security was reaffirmed in the International Covenant on Economic, Social and Cultural Rights (1966) in Article 9[7]:

"*The States Parties to the present Covenant recognize the right of everyone to social security, including social insurance*",

and its inseparability from the right to health as established by the CESCR in its General Comment No. 19 on Social Security in 2007[8]:

"*States parties have an obligation to guarantee that health systems are established to provide adequate access to health services for all*".

The ILO's Social Protection Floors Recommendation, 2012 (No. 202)

Stipulation of the rights to social security and health are at the core of the International Labour Organization's Social Protection Floors Recommendation, 2012 (No. 202)[9], in which access to health care is the first of four basic social security guarantees, inseparably part of social protection:

"*…access to a nationally defined set of goods and services, constituting essential health care, including maternity care, that meets the criteria of availability, accessibility, acceptability and quality*".

The rights to health and to social protection are the essence of human development

Social protection as conceived in the ILO Recommendation constitutes the first goal of the Sustainable Development Agenda 2030, which was drafted three years later and adopted by UN Resolution in 2015[10], to:

"*End poverty in all its forms everywhere*" (Goal 1),

within which the third target is to:

"*Implement nationally appropriate social protection systems and measures for all, including floors* […]".

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[6] UN General Assembly, 1948, op. cit.
[7] UN General Assembly, 1966, op. cit.
[8] UN Committee on Economic, Social and Cultural Rights (CESCR), 2007. *General Comment No. 19: The right to social security (Art. 9 of the Covenant)*. Adopted on 23 Nov. 2007 and issued 4 February 2008.
[9] International Labour Organization (ILO), 2012. *Recommendation Concerning National Floors of Social Protection* (R202). Adopted at Geneva, 101st ILC session (14 Jun 2012).
[10] UN General Assembly, 2015. *Transforming our world: the 2030 Agenda for Sustainable Development.* Resolution adopted by the General Assembly on 25 September 2015 [A/RES/70/1] and issued 21 October 2015.

Hence social protection and, inseparably, health, together comprise the first and fundamental goal of the Agenda for Sustainable Development to which all nations subscribe. In purely moral, humanitarian and human-centered terms, they comprise the essential rationale for development, served by all the other goals of that Agenda.

The strength of the social protection umbrella for health is all the more important when contrasted with the weakness of the health goal of the Sustainable Development Agenda 2030, to:

> "*Ensure healthy lives and promote well-being for all at all ages*" (Goal 3).

Following the enunciation of seven narrowly defined health targets, the notion of universal access to health care is only the eighth target listed, and it is, furthermore, diluted by the target being also used to stress the importance of two additional specific universal interventions; access to essential medicines and vaccines for all:

> "*Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all*" (Goal 3.8).

In effect, all the specific targets spelled out in the Sustainable Development Agenda Goal 3 would indeed be redundant in the case of truly universal coverage and access to quality essential health care services, which comprise the fundamental and all-encompassing goal.

Striving towards universal access to comprehensive health care

One might think that strengthening and expanding existing care structures with more resources are enough to achieve universal access. Past progression and current deployment of care have, however, followed other pathways and served other purposes. A multiplicity of systems has arisen from diverse policies, with unequal results.

In countries that have pursued universal access, health care delivery based on quasi-public social insurance systems have contributed to a good status of health, judging by morbidity and mortality indicators[11].

At the other end of measures of human wellbeing, countries with weak systems often dependent on external aid show deplorable health status levels. They may show segmentation of access to care and in care itself. A local health center might ensure postpartum and newborn care, even childhood vaccinations, but balk at pregnancy or delivery complications, a broken leg, or a traumatic injury, requiring a means of referral to a next level of care, that may or may not be in place[12].

Lacking cohesive systems, they may be subject to donor objectives of measuring impact based on short-term visible intervention effectiveness rather than successful health outcomes in the longer-term. Such micro-goals are valid, but lack scope, with health reduced to the success of multiple micro-interventions. Furthermore, if each micro-intervention is sponsored by a different donor, demonstrating success becomes a competition that reinforces intervention differentiation to the detriment of silent improvements in health infrastructure.

[11] This applies to European and other nations, in particular the post-World War II welfare states.
[12] This applies to a number of developing nations, in particular among the least developing countries in Asia, Africa and the Americas.

Yet other countries show coexisting high-quality private care and lower quality public care. Two-tier systems arose as the profitability of medical interventions visibly interested the financial world. The for-profit yet health-dedicated medical and pharmaceutical industries have been overtaken in sectoral investments by financial funds in search of higher profitability.

The stake of profitability in delivering health is considerable. At present, annual global health expenditure hovers around 10 trillion US dollars. By comparison, annual global military spending is around 2 trillion, or 5 times less. There is forceful pecuniary motivation to privatize health as widely and deeply as possible.

Universal access to health care means going against the grain and overcoming obstacles these trends pose. Health must be redefined comprehensively, rather than as a haphazard assembly of elements. The objectives of reducing morbidity and mortality must apply to the entire population and employ interventions on all disease causes, neither relying on interventions selected to bring rapid and measurable results, nor emanating from donor priorities, nor again meeting only the priorities of privileged strata. Importantly, it calls for greater public and national investment to build health systems that achieve the essential goal of truly equitable and universal access. That requires redistribution in public spending, tax justice, and increased fiscal accountability of financial flows to thwart tax evasion and avoidance on profits and to address the ever-yawning wealth gaps. The 2021 OECD and G20 global minimum tax agreement advances this agenda[13].

Universal access to care requires stronger multilateral collaboration and solidarity through both WHO and UN programmes and agencies that address health and international financial institutions – the development banks and the Bretton Woods institutions. It requires greater flexibility from international financial institutions regarding national budgets to enable spending on health and social protection such as tolerating deficits, allowing modification of budget allocations and treating loans and grants in general budgets.

COVID-19 revealed deep structural failures

The root cause of COVID-19 transmission and its unequal mortality lie in structural failures. Economic inequality is ineluctably linked to social inequality and to the excess burden of ill health of the underprivileged.

If arguments on the inseparability of social protection and health are not persuasive enough, recent epidemics have demonstrated it with prodigious clarity. In 2014, the Ebola epidemic in West Africa conclusively showed the need for functional and effective health systems to counter epidemics[14]. Emergency intervention was insufficient: an infrastructure was needed with prevention protocols and intervention procedures, however rudimentary. The epidemic was aggravated by transmission within existing health facilities because health workers lacked even basic protective equipment when providing care. A deplorable death rate in healthcare workers resulted, damaging the future of essential care. Only the massive intervention of organized and fully equipped external actors overcame the outbreak.

Yet it happened again because the lack of investment in health systems persists, with the exception of that likely to bring monetary returns, and has further burdened poor populations, this time also in developed countries. The COVID-19 pandemic has caused widespread morbidity and unequal mortality against imbalanced access to resources and persistent inadequacy of health systems.

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[13] Organisation for Economic Cooperation and Development OECD), 2021. *Statement on a Two-Pillar Solution to Address the Tax Challenges Arising from the Digitalisation of the Economy*. Issued 1 July 2021 and finalised 8 October 2021.

[14] Frank Odile, 2015. *EBOLA: Global politics and the healthcare workers' perspective.* Information brief. Ferney-Voltaire: Public Services International (May).

Vaccination distribution has convincingly shown up global inequity. Once again, the disadvantaged and health workers have paid with their lives for the failures and shortcomings currently characterizing the implementation of health systems policy and management.

Wrong responses are perilous and loom large

There are several possible wrong responses to the pandemic. The first is to dissociate countries faced with the same challenge. Such an approach perpetuates root causes of pandemics and is not in the best interest of any population. To the contrary, harmonized strategy is required for solidarity with poorer countries and within countries between rich and poor to achieve improved global health security. Whereas disadvantaged populations are the most vulnerable, older persons and all persons with pre-existing pathologies are vulnerable everywhere.

It would also be a mistake to respond by focusing actions and investments on hospital settings and equipment for intensive care that was found so lacking. Health systems will grow and be strengthened by disseminating prevention training and distributing essential equipment as widely as possible to broaden their availability to the populations. This requires the construction of truly essential health services, capable of providing a range of preventive and curative care and, importantly, with the capacity of contributing to epidemiological surveillance. It is through the networks of such systems that the response to inevitable future epidemics will be managed.

With respect to loans and grants from international financial institutions, they must not be systematically redirected to alleviate the consequences of COVID-19, because there is a risk that invaluable resources will be spent on recurrent needs. It is imperative rather to build the infrastructure needed to improve living conditions, including universal social protection that addresses the root causes of poverty and ill health, and to increase resilience to health emergencies.

While satisfying, short-term responses are not satisfactory, catering for immediate and visible results rather than lasting change. It is necessary to plan over time, to build solidly and systematically, to improve in depth, to evaluate methodically and to apply the results with studied persistence.

And as the pandemic recedes, it would be a grave error to return these objectives to the back burner. Although no longer in the limelight and lost to political popularity, the fundamental changes needed must have the resources to continue to proceed. Our improved survival in future epidemics depends on that progress.

The need for political will

Such change is the work of populations and societies, through their representatives, governments and administrations, and with the compelling contribution of their civil society structures, trade unions and movements. Building universal access to essential health care requires political determination, greater fiscal justice, reoriented budgets and greater regulation of privatization, including increased and smarter oversight of private health services. Privatized health should be at the service of the public health systems in which it is implanted, and therefore serve the objectives of the health policy that regulates it. Profitability should not be used to motivate or direct national health systems. We know today that the privatization of health does not alone bring efficiency or savings and costs more to taxpayers in the long-run. Furthermore, private services contribute little to universal and equitable access to health care.

The legacy of commitment

We have known for decades that universal access to essential health care and social security are inseparable, and constitute the two pillars of social protection. We cannot achieve one without the other. Repairing national failures to deliver health while building stronger social protection systems

means repairing our societies themselves by stripping them of the greatest inequalities and injustices, no more and no less.