

EDITORIAL

Economic Inequality and the Right to Health: On Neoliberalism, Corporatization, and Coloniality

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The emergence of neoliberalism 50 years ago has led to a marked increase in economic inequality and an undermining of economic, social, and cultural rights. The papers in this special section examine the role of neoliberal policies in exacerbating economic inequality, while at the same time considering how these policies deliberately prevent efforts to progressively realize the right to health. Drawing on international human rights, several papers also propose actions to reduce economic inequality and create conditions favorable for realizing the right to health and human rights more generally.

The *Global Wealth Report 2022* “estimate[d] that the bottom 50% of adults in the global wealth distribution together accounted for less than 1% of total global wealth at the end of 2021. In contrast, the richest decile (top 10% of adults) own[ed] 82% of global wealth.”¹ Further, Oxfam reported in 2023 that globally, over the past two years, the wealthiest have become much wealthier, while at the same time, “poverty has increased for the first time in 25 years.”² Neoliberal policies have actively embraced free market capitalism and economic inequality and rejected ideas of solidarity by restructuring economies, privatizing, deregulating, reducing taxes on the wealthy, and transferring the obligations of states to private entities.³

All governments make political choices in allocating funding to and within the health sector. They decide whether to meet their right to health obligations as well as their international human rights duty to ask for or offer assistance to other states to meet their right to health obligations. COVID-19, especially until the rollout of vaccines, demonstrated the capacity of states to respond to crises when good health depended on health for all. Admittedly, some did much better than others at ensuring the economic protection of low- and middle-income populations, as well as equitable access to care and vaccination. But the global commitment to “build back better” now rings hollow, and attempts to respond to climate change using the same existential-crisis framing are few and far between. Overall, there has been a failure to respond to what should have been the most important lesson to come from the pandemic: good physical and mental health are fundamental to life and to our communities, and without good health, economies and societ-

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ies cannot thrive. In terms of human rights, if the right to health is not realized, nor will any other economic, social, cultural, civil, or political rights be truly fulfilled.

While there are numerous examples in which the right to health framework has successfully advanced policies to respect, protect, and fulfill the rights of marginalized groups, we recognize that the right to health is rarely invoked to address the root causes of economic inequality. Rather, the dominant interpretation of the right to health, accommodates—if not facilitates—the social atomization and market fetishism core to the neoliberal political project, which has increased economic inequality.

To address economic inequality and the right to health, states must change fiscal policies that remain focused on neoliberal goals such as those that promote unsustainable growth and ignore the plight of the majority and the planet. If universal good health had been afforded prominence, the health workforce would not be in its current precarious state, facing a projected global shortage of about 10 million workers by 2030, spread unequally, with the worst shortages expected in the lowest-income countries with the most need.⁴ To fulfill an equal right to health, states must invest in health workers and in health infrastructure, and stop the egregious gouging of the health dollar by the private sector, especially in the for-profit health insurance and pharmaceutical sectors. Yet with few exceptions, the role of fiscal management in contributing to increased economic inequality and unequal access to health care and the social determinants of health has not been examined by right to health scholars.⁵

The papers in this special section address economic inequality and the right to health, examining health care systems and the social determinants of health in the context of neoliberalism and in light of the recent and current crises of gross economic inequality, austerity measures, climate change, and COVID-19.

Neoliberalism and the right to health

Three of the papers examine the impact of neoliberalism on the right to health, considering the political dynamics of the post-COVID-19 context, the United Nations treaty bodies' consideration of private actors in health care systems, and the consequences of development finance institutions funding private for-profit health care with taxpayer funds from wealthy countries. In the first paper, Ted Schrecker argues that post-COVID-19, we have reached a “tipping point” in terms of economic inequality, making it more difficult, if not impossible, to realize health as a human right. He predicts, pessimistically, a gradual deterioration of tax-financed universal health care and greater health inequalities as the wealthy members of society are increasingly able to translate into policy their opposition to financing health care for those less well off. The post-COVID-19 era, he foresees, is likely to continue the “hegemony of neoliberal or market fundamentalist perspectives domestically and internationally” in continual detriment to the right to health.

Private actors form an important component of this neoliberal project, according to authors Rossella De Falco, Timothy Fish Hodgson, Matt McConnell, and A. Kayum Ahmed. In their paper, they survey statements from United Nations treaty bodies, the Special Rapporteurs on the right to health, and the African Commission on Human and Peoples' Rights concerning the involvement of private actors and the right to health. Like Schrecker, they believe that the “commercialization of health care systems still does not appear to have reached its zenith.” Nonetheless, they argue that several normative developments, including growing skepticism of the compatibility of private actors in health care with the right to health, present opportunities for treaty bodies to interpret the right to health to require inequality-reducing measures. In this respect, they suggest several ways for treaty bodies to increase their efforts to reduce

commercialization and economic inequality toward realizing the right to health.

In the third paper, Anna Marriott, Anjela Taneja, and Linda Oduor-Noah examine whether a sample of European development finance institutions and the International Finance Corporation are meeting their obligations regarding the right to health. The authors find that more than 50% of these entities' investments in health have gone to the private sector, which is not well regulated or held accountable for realizing the right to health. They conclude that this investment approach is placing significant barriers for many people to access quality, affordable health services and thereby limits the realization of the fundamental right to health for all. Based on this analysis, the authors recommend that high-income governments and the World Bank not fund any future for-profit private health care projects through development finance institutions unless various steps are taken, including strengthening these institutions' approach to human rights due diligence through greater transparency, nondiscrimination, monitoring, and accountability.

The right to health as a redistributive project

Four papers examine the redistributive potential of human rights, focusing on social protection, universal health care, the conception of equality in human rights law, and climate change. First, for Joo-Young Lee, economic inequality is a key social determinant of health, and social protection is essential for ensuring an adequate standard of living while simultaneously reducing economic inequality. The COVID-19 pandemic highlighted "the need for a robust social protection system, including income protection, family and child support, and health care"; however, there remain large gaps globally. In this context, Lee revisits international human rights law, maintaining that it offers a normative

foundation for a transformative social protection system. More specifically, she looks to both the right to social security and the International Labour Organization's Social Protection Floors in Recommendation No. 202 to provide "a firm normative basis for the requirement of comprehensive universal coverage for protection against social risks."

Second, Anja Rudiger argues compellingly in her paper that advocates for the right to health should embrace universal health care as "a redistributive project" that can contribute to advancing not only the right to health but also serve as a mechanism to reduce economic inequality. She contrasts the market-based health care system in the United States with a truly universal health care system, focusing on (1) who pays for it?, (2) who has ownership of it?, and (3) who governs it? While she recognizes that traditional human rights advocates may resist the ideas of redistribution, public ownership, and co-governance, she argues that greater economic equality through such measures must be at the heart of efforts to realize the right to health for all.

According to Michael Marcondes Smith, economic policies—such as austerity measures—that concentrate wealth and increase economic inequalities often have negative impacts on human rights. Yet austerity measures are justified on the basis of supporting growth and trickle-down economics, which would ostensibly eventually result in the realization of human rights. Marcondes Smith maintains that the general assumption that human rights may be sidelined and postponed while economic inequality increases suggests a problematic conception of equality in human rights law. In his paper, he critically examines the way this assumption informs the exclusion of distributive considerations from the scope of equality within human rights law. He proposes a reinterpretation of equality in human rights that "may take on a distributive function in combating policies of wealth concentration such as austerity."

Thalia Viveros-Uehara's paper on climate change and economic inequality draws on the human rights framework "to chart a more transformative course toward a distributive, corrective, and procedural balance" that advances the socioeconomic conditions of marginalized groups. Viveros-Uehara recommends that in addition to addressing climate mitigation (such as reducing greenhouse gas emissions), we must also address climate adaptation (such as building more resilient health care systems). She provides an overview of actions by international organizations, domestic courts, civil society, and research communities to show that almost all their attention is focused on mitigation. She argues that instead we must focus greater attention on "the urgent provision of accessible, acceptable, quality, and resilient health care" for those most at risk of health impacts flowing from the climate crisis.

Intellectual property and inequality

Two papers in this special section reflect on the intellectual property regime as a mechanism that contributes to economic inequality. Thomas Pogge's paper critiques the current intellectual property regime—the patent system governed globally by the World Trade Organization—referring to it as "a toxic regime for rewarding important pharmaceutical innovations, one that persistently harms and kills millions of people around the world." In particular, Pogge explains how this system increases economic inequality and indeed is supported by economic inequality. In response, he proposes a Health Impact Fund to complement the patent system, whereby inventors of important new medicines would be rewarded based on the extent to which their medicine has improved health. Rather than limiting medicines to those who can afford them and thereby allowing diseases to continue to spread among populations, the Health Impact Fund would encourage inventors to address diseases

among the poor, as they would be compensated for doing so. Such a system for remuneration of research on medicines would greatly reduce economic and health inequalities and contribute to realizing the right to health for all.

Luciano Bottini Filho suggests the need for a more comprehensive approach to manage scarcity in health care. In his paper, he examines various areas underemployed as part of the state obligation to maximize resources—as required by article 2 of the International Covenant on Economic, Social and Cultural Rights—and identifies a range of legal determinants of scarcity that can be used to positively influence the availability and affordability of health technologies aside from intellectual property (patent) laws. In particular, he recommends that states adopt complementary policies such as direct price control, price negotiation and contractual mechanisms, competition laws, and public-private partnerships. While scholars have written extensively about the impacts of patents on the right to health, Filho introduces new avenues to explore in law.

Reimagining the right to health

The papers in this special section have led us to conclude that under a neoliberal organization of the global economy, which privileges the maximization of private interests over the realization of rights and collective well-being, economic inequality will soar and the right to health for all will remain unrealized.

The World Health Organization has attempted to expand on the social determinants of health by including the commercial determinants of health. As it explains:

The social determinants of health are the conditions in which people are born, grow, work, live, and age, the systems put in place to deal with illness, and the wider set of forces and systems shaping the conditions of daily life ... Commercial determinants

of health are a key social determinant, and refer to the conditions, actions and omissions by commercial actors that affect health.⁶

The *Lancet's* 2023 series on the commercial determinants of health recognizes the damaging effects of neoliberalism on the realization of the right to health.⁷ Rethinking and regulating corporate practices could potentially move us closer to addressing the underlying structural flaws baked into the neoliberal world order. At the same time, the *Lancet's* conception of the commercial determinants of health is limited to for-profit actors and does not address the harmful practices of other private entities operating within a market logic exactly as a commercial entity would, such as non-profit hospitals and health insurance companies in the United States and private foundations globally.

One emergent idea that we offer as a provocation is to consider reconstituting the right to health as a “decolonial option.” For Walter Mignolo, decolonial options derive from acts of “epistemic disobedience,” or delinking from Euro-American constructions of universal knowledge centered on capitalism, patriarchy, and white supremacy.⁸ Furthermore, epistemic disobedience requires engaging with knowledge and ideas that have traditionally been marginalized by Western modernity, such as Indigenous knowledge systems.

Instead of merely defending people living in poverty through inadequate social protection floors, or reducing inequality inadequately through the Sustainable Development Goals, human rights must work toward dismantling the violence of the neoliberal architecture that reproduces poverty and inequality.⁹ The papers in this special section open various avenues to advance this cause.

By delinking from the principles of neoliberal ideology—such as self-interested individualism, wealth accumulation, and economic inequality—and linking with marginalized epistemologies and peoples, human rights can begin a process

of regeneration. The right to health continues to serve as a valuable framework for challenging the profit-centered approach to health. Its evolution in response to the commercial determinants of health should also be supported. But given that the right to health remains open to corporate capture, some fundamental shifts are urgently needed. We argue that the right to health must be explicitly decolonial for the right to health to serve as a framework for global health equity.¹⁰ This shift toward decoloniality will contribute to dismantling the neoliberal logic that underpins the global health architecture.

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