



FUNDAMENTALS OF PUBLIC HEALTH

## Population Health and Human Rights

Julio Frenk, M.D., M.P.H., Ph.D., and Octavio Gómez-Dantés, M.D., M.P.H.

Should access to health services be considered a human right? This is one of the fundamental ethical and political questions facing every society, but both the answers and the ways in which

countries have acted on them vary substantially.

Until shortly after the turn of the millennium, Mexico had been unable to achieve universal health coverage, primarily because — as in the United States — access to insurance was conceived as an employment benefit rather than as a social right. Half the Mexican population consisted of salaried workers and their families, who received coverage through several social insurance schemes. The other half comprised self-employed workers and their families, most of whom were poor and at risk for catastrophic health expenditures because they were uninsured. In 2004, Mexico launched a reform to achieve universal cov-

erage through a public scheme called Seguro Popular, aimed at the uninsured population.<sup>1</sup> By 2018, before the current populist government decided to dismantle it on ideological grounds,<sup>2</sup> Seguro Popular was the largest health insurance program in the country, covering 58 million people with a comprehensive set of services ranging from community-based preventive interventions to primary and specialty clinical care.

The 2004 reform was guided by a human rights framework: its point of departure was the principle that health care is not a commodity or a privilege, but a social right (see table). This tenet reflects the 1948 Universal Declaration of Human Rights, which

established the basis for the promotion of justice in health by identifying core social rights applicable to every person and establishing governments' obligation to create the means to guarantee them.

In Mexico, the right to health protection had been recognized by the country's constitution since 1983, but it took 20 years to operationalize that right by defining its scope and resulting entitlements. The reform launched in 2004 provided instruments to achieve social protection in health along three dimensions: health-risk protection, by means of a fund to finance public health interventions addressing environmental, behavioral, and social risks, as well as a new, science-driven regulatory agency; patient protection, aimed at ensuring the safety, effectiveness, and quality of clinical care through facility accreditation, provider certification, technology assessment, and

continuous-improvement strategies; and financial protection, aimed at reducing out-of-pocket payments through coverage of a comprehensive set of entitlements under Seguro Popular.

Seguro Popular's architects designed a transparent process for prioritizing and estimating the costs of entitlements. Funded mostly by federal taxes, with supplemental state contributions and small, means-tested family premiums, the program ultimately guaranteed access to two packages of interventions: 294 preventive and therapeutic services for conditions with high incidence and relatively low cost, delivered in primary care clinics and general hospitals, and 66 high-cost

promotes human rights shapes public policies, determines the distribution of resources and access to services, and ultimately affects population health. Since the public health field is defined by analysis at the population level, scholarship and action on human rights have been foundational to the field.<sup>3</sup>

The study of population health encompasses two main objects of analysis: the health conditions affecting a population (the frequency, distribution, and determinants of diseases and risk factors) and the organized social response to those conditions, particularly the way in which that response is articulated in the health system, including the principles

through public assistance programs covering families with incomes below a predetermined level or through social insurance schemes for prioritized groups (e.g., the armed forces, industrial workers, civil servants, or older adults). All these eligibility principles result in only partial coverage, but the ideal of universality has influenced public policy in most countries, though the design and performance of health systems vary widely.

Public health experts have vigorously debated whether societies can guarantee the right to health itself or only to health care. One answer is suggested in the 1946 constitution of the World Health Organization (WHO), which says both that "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being" and that "Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures."

The first statement recognizes the relative character of the right to health by implicitly acknowledging that, at any historical moment, it is possible to attain only a certain level of health, given the state of science, technology, and social organization and the uncontrollable nature of most genetic determinants of health.

The second statement recognizes the essential link between health and the major means for achieving it — provision of health care, alongside public health interventions and other services addressing social determinants of health, such as education and housing. A more recent elaboration of the right to the highest

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interventions for conditions that could have catastrophic consequences for families, delivered in specialty units.

Mexico's experience illustrates how the abstract notion of human rights can be translated into policies and programs with large positive effects for populations. The concept of human rights offers a framework for addressing a fundamental health policy question: how best to allocate limited health care resources and do so in a way that safeguards other rights associated with the process of care, such as confidentiality, informed consent, and respect for human dignity. The way in which a society protects and

and rules that determine who has access to which services and at what cost to whom. These services include both clinical and public health interventions.<sup>4</sup>

Since the 19th century, national health systems have sought to provide health services to an increasing proportion of the population, using four eligibility principles: purchasing power, poverty, socially defined priority, and social rights. Reliance on purchasing power means that access is determined by ability to pay, with governments limiting their role to basic regulation. Because this principle excludes many people, governments have historically intervened to expand access, either

A Human Rights Framework for Public Health.		
Type	Characteristics	Examples
Civil and political rights	Civil rights protect the freedom of individuals from abuses by governments, social organizations, or private entities. Political rights guarantee the participation of citizens in political power, either as elected authorities or as members of a body of voters.	Protection from discrimination based on race, sex, health status, and other factors Right to privacy and confidentiality regarding personal health data Right to informed consent regarding medical interventions or participation as a research subject
Social rights	Social rights deal with the satisfaction of basic needs.	Right to an adequate standard of living, education, work, or housing Right to the highest attainable standard of health (as specified by the World Health Organization Constitution) Right to health care coverage and improvement of environmental conditions that affect human health.
Group rights	Group rights focus on collective concepts such as community and cultural heritage. Beneficiaries are social groupings or entire societies.	Rights to natural resources, a healthy environment, and sustainability
All human rights	Governments must actively participate in order to respect, protect, and fulfill human rights. The various types of human rights are interlinked. Respect for human rights is essential to fair and inclusive health care and public health efforts.	Rights to many goods, services, and resources that determine health Right to health care, allowing realization of civil, political, and social rights Right to equitable inclusion in responses to public health crises such as epidemics or climate change

attainable level of health reflects such a broad view, encompassing both health care and related services.<sup>5</sup> This view underscores the need to establish strong links among various social rights. In addition, a health system's structure and performance (themselves determined by social forces) are key factors constraining the attainable level of health at a given time and place. Therefore, realizing the right to health care is a principal means for realizing the right to the highest attainable standard of health.

Two main approaches have been proposed for setting that standard. One uses a normative criterion that applies everywhere (e.g., the biologic limit of human life). The other is based on an empirical criterion: the highest observed level of health within or among countries, as measured by indicators such as life expectancy at birth or infant mortality. For international comparisons, there is the additional question of

whether the relevant standard should be selected from all other countries or only from those with similar socioeconomic conditions. Whatever criterion is used, the gap between the maximum attainable and the actually attained level of health indicates the extent to which a society falls short of fully realizing the right to health. The elements of that gap that are attributable to less-than-optimal health system performance represent opportunities for improving the realization of the right to health through policies and programs.

All United Nations member states have recognized the right to health care in various international agreements, and universal health coverage is a target of the Sustainable Development Goals approved by the UN General Assembly in 2015. But less than half of UN member states explicitly recognize this right in their constitutions. Moreover, recognition is clearly not enough: many


countries have established constitutional provisions but have poor records of implementing health care rights, whereas others lack these provisions yet have health systems that deliver high-quality services with financial protection to everyone.

The realization of the right to health care by everyone regardless of social, economic, or labor status faces multiple challenges. One of the most complex stems from the striking variations in the performance of health systems among countries at similar levels of economic development and health care expenditures. Such variations lead to large disparities in accessibility and quality of services, which generate deep inequities in health outcomes within and among countries.

To advance the realization of the right to health care, certain practical conditions must be met. The specific health benefits to which all persons have access must be defined, a mechanism

must be established empowering people to legally demand such benefits, and financial schemes for fair and sustainable distribution of costs must be adopted.

Implementation of the right to health care can start with what the International Covenant on Economic, Social and Cultural Rights calls “minimum core obligations,” which should be expanded gradually as resources expand. Again, such obligations are not limited to health care,

 **An audio interview with Dr. Gómez-Dantés is available at NEJM.org**

but also include related services that act on social determinants of health. Priorities for health care can be defined with such criteria as cost-effectiveness, burden of disease addressed, and social acceptability, which implies adherence to professional norms and widely held values. The process of defining priorities should also aim for “procedural justice,” or fairness and transparency of de-

cision making. The ideal of fairness is intertwined with human rights, which tend to protect the most vulnerable.

In addition, monitoring and evaluation mechanisms are required to ensure that initiatives designed to progressively realize the right to health care are on track, according to budgetary and health indicators and analyses of policies and laws. These mechanisms can be designed and operated by ombudspersons, academic institutions, global or regional multilateral agencies, philanthropic groups, or civil society organizations.

At a time when all countries face common threats of pandemics, climate change, and social inequality, the universal character of human rights offers a shared opportunity to protect and promote the health of populations worldwide.

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## Covid-Induced Changes in Health Care Delivery — Can They Last?

Rachel M. Werner, M.D., Ph.D., and Sherry A. Glied, Ph.D.

Covid-19 shook the U.S. health care system. The immediate-term fallout was predictable: in-person utilization plummeted and many adults deferred routine care. Health care professionals, hospitals, and patients had to — and did — adapt rapidly to this unprecedented crisis, quickly flexing to increase the use of delivery modes such as telemedicine and home-based care.

Today, widespread vaccination

is beginning to bring the pandemic under control. But will the pandemic-induced changes to health care delivery last as the pandemic itself fades? They may, given that they reflect trends that began before the virus emerged. But the rapid pace of change during the pandemic revealed the limitations of these new delivery modes and raises questions about whether our current health care system, and its financing, can

support these changes and ensure that they improve quality and equity.

Telehealth is not new — Medicare has paid for rural beneficiaries' telehealth visits since 1996. But regulations made its use cumbersome, with restrictions on where patients could receive these services and which providers could be paid to deliver them; even when telehealth was available, payment rules made its coverage