HUMAN RIGHT TO HEALTH, SOCIAL RIGHTS AND HUMAN DIGNITY VERSUS RELATIVIST CHALLENGE OF NEOLIBERAL CAPITALISM

GALYM ZHUSSIPBEK[1]

Abstract: Human rights to health and health care have developed considerably since they were first codified after World War Two and now, they are regulated in many international and national legal documents. Nevertheless, health rights still face many challenges. They are among the most contested, incompletely conceptualized human rights and the least enforceable rights. This paper argues that the greatest challenges and difficulties in health rights stem from the global expansion of neoliberal capitalism to which positivist epistemology is complacent. These problems entail the relativist challenge to the universality of human dignity and the neglect of fundamental values such as caring, empathy and respect for human dignity. The neoliberal capitalist mindset leads to an erosion of empathy, which translates into hostility towards, or at least neglect of, social human rights. All this contributes to the normalization of narrow understandings of health and the human right to health and to the problematic development of health rights. The commodification of health care led to a paradigm shift in the health sector creating an impersonal, profit-centric relationship. The insufficient role of the World Health Organization is one of the main reasons for the underdevelopment of health rights. Nor can the concept of sustainable development be seen as truly inclusive and conducive to the development of viable health rights, as the problems in the development of universal health coverage show. This paper suggests that the creation of fully-fledged health rights is not a problem of resource scarcity or lack of legal norms — but primarily a problem of scarcity of care and empathy, and a lack of understanding of the universality of human dignity. To make health and health care full-fledged human rights requires, first and foremost, a cultural transformation and mental revival, which would revive care, empathy, and dignity; the development of social rights that are indispensable for the protection of human dignity; and the implementation of a solidaristic perspective with full decommodification of health care.

Keywords: Care, Dignity, Human right to health, Health care, Human rights, Social rights, Neoliberal capitalism, Sustainable development.

1. Introduction

Health must not be treated as a luxury. This is a key lesson learnt from the COVID-19 pandemic (Turk, 2024). Another key lesson is that the pandemic became a stark reminder of the divide that exists in countries without universal health care (Khoo & Lantos, 2020) (following Issel (2014), this article uses the term "health care" instead of "healthcare"). The countries with health care systems based on universal access to services and a well-funded and organized approach to public health coped much better with the pandemic (Waitzkin, 2021, p. 204).

As of 2014, 69% of constitutions worldwide contained health-related guarantees, while the right to health was justiciable in 41% (Jung et al., 2014). It is a logical and

[1] Independent scholar based in Almaty; a faculty member at the Department of Social Sciences, SDU University, Kaskelen/ Almaty, Kazakhstan (galym.zhussipbek@gmail.com; asym22@yahoo.com).

should-be result if we consider that human right to health was declared formally in 1946 by the World Health Organization (WHO) and subsequently codified by leading international documents in the field of human rights. But for all these formal achievements, there are still extreme inequalities: health care spending per capita for the top 5% of the world population is nearly 4,500 times that of the lowest 20%. (Flood & Gross, 2014). However, what is more striking is that the right to health is still the most disputable and practically the least enforceable. As noted long before the COVID-19 Pandemic (Tobin, 2012), debates on the conceptual underpinnings of the right to health are still ongoing, and the right to health continues to face many challenges of a legal, political, economic, and cultural nature in today's world.

This paper argues that neoliberal capitalism (which tends to absolutize the logic and mechanisms of the free market and promote the values of egocentric individualism and self-help (Amadae, 2016) can be seen as the main reason why the right to health is portrayed as one of the most "subversive human rights" (O'Connell, 2010) and as a human right with "shaky" conceptual foundations or "incompletely conceptualized" (Tobin, 2012). Among other things, the beginning of the global advance of the neoliberal economic paradigm led to the failure of the "Health for All" strategy adopted by the 1978 Alma-Ata Declaration (Meier, 2010A, p. 47).

On the other hand, the role of positivist epistemology in understanding social phenomena (which is distinct from positivism in legal theory) should be considered in any thorough analysis of the insufficient development of health rights. The tendency to downplay the role of emotions (including positive ones such as empathy, which is key to legitimizing the universality of human rights) and to separate reason and emotions, intellect and values, is an epistemological problem of a positivist approach that characterizes the neoliberal capitalist mindset (one of the main themes of this article). (Barreto, 2006; Sayer, 2017a). It is logical that there is a widespread distrust of empathy among lawyers and legal thinkers. (Corso, 2014). Sociology, which like other social sciences has been shaped mainly by positivist epistemology, has also long been deficient in defending human rights. Turner (1993) criticizes the skepticism of classical sociology towards the universality of human rights, which is rooted in relativism and the influence of "hard-core" positivism.

This paper adopted the broad understanding of health inspired by the so-called bio-psycho-social model. As a comprehensive model that views health as a dynamic interaction between biological, psychological, and social factors, this model was developed as an alternative to the conventional bio-medical model and was first formally conceptualized by psychiatrist Engel in 1977. However, neoliberal capitalism, being extremely empiricist, promoted bio-medical or bio-statistical understandings of health. Since the 1990s neoliberal capitalism as a mode of discourse turned out to be hegemonic by being incorporated into the common-sense way many perceive, live in, and understand the world. Though the primary idea was to increase efficiency and quality of human efforts in all sectors, neoliberalism's market-centric morality led to relativization of human dignity, creation of hierarchies of worth, silent acceptance of human beings as "disposable and expendable"; instrumentalization of human rights, which affected negatively the development of viable health rights.

Also, despite many medical and technological advances, the benefits of health care for many ordinary citizens remain limited due to neoliberal reforms in social and economic policy and the health care system. Hence, the delivery of health care was (Gaffney, 2017, p. 220) and is still far from perfect, though we as humankind has enough financial, technological resources and good laws. The pandemic has proved that class and racial inequalities, employment, education and housing conditions determine health and that the social determinants of health have implications that go beyond the health care sector (Yamin, 2008). In fact, we have a world that allows people to die if they do not have financial means. (Khoo & Lantos, 2020).

Overall, the value of moral sympathy is crucial to the development of universal and extraterritorial human rights (Turner, 1993). This paper argues that the development of human rights to health and health care depends on the internalization of the values of care, empathy, and universalistic understanding of human dignity, which are accepted and promoted by the naturalistic conception of human rights that is a foundation of all major international human rights documents. The naturalistic conception holds that human rights are first and foremost moral rights that all human beings are entitled to at all times and in all places simply because they are human beings (Cruft et al., 2015, 1). Overall, the values of care and empathy in the theoretical defense of human rights can be supported by the assumptions of critical realism and the ethics of care, which are discussed below.

The COVID-19 pandemic has highlighted the dangers of a bio-medical or bio-statistical understanding of health that separates health from well-being, social and political factors. Furthermore, the pandemic has shown that the Sustainable Development Goals (SDGs) adopted by the United Nations (UN), such as the achievement of Universal Health Coverage (UHC), do not include a conceptually sound analysis to address issues of social, environmental and relational inclusion that lie behind the multi-layered crisis caused by neoliberal capitalism. Thus, the pandemic exposed a number of fundamental crises that were already present in the pre-COVID system in the area of SDGs (Gupta et al., 2021). The concept of sustainable development cannot be seen as truly inclusive and conducive to the development of health rights when applying the critical analyses of inclusive development scholars. As the COVID-19 Pandemic posed unprecedented challenges to human rights in global health, the concept of human rights became an essential requirement for the UN and WHO to respond to the health harms of a globalizing world (Meier et al., 2023). Although the UN and WHO have moved to a more rights-based approach that recognizes the role of social determinants of health, their efforts are insufficient to develop full-fledged human rights to health and health care.

There is extensive research that addresses the negative effects of neoliberal capitalism on health rights. However, as an interdisciplinary and conceptual-normative one, this paper has two central aims: (1) to discuss the right to health in a broad context, applying a non-positivist epistemology and concepts such as care, empathy and dignity that are overlooked in positivist research, and (2) to offer some solutions that focus on systemic change, the development of social rights and a solidarity perspective, and most importantly, cultural change and moral revival. This can be possible by internalizing the primacy of care, concern and dignity in personal and social life.

2. Primacy of care and universality of human dignity

Conceptually, this paper is based on the fundamental ideas proposed by critical realism that care is what human beings need existentially, that dignity is connected to care (Sayer, 2011) and that rights far from being only abstract concepts, are real because they exist on four main areas or planes of social being: bodies in material relations with nature, interpersonal relations, social structures, and inner being (Alderson, 2016).

To overcome the limitations that positivism entails in many social sciences and to develop universal and extraterritorial human rights, the value of moral sympathy (empathy, one of the main concepts in this article, is commonly associated with sympathy (see e.g. Corso, 2014) is crucial. Moral sympathy gains a fundamental role in the face of human frailty, precariousness, and the instability of social institutions. (Turner, 1993), which critical realism and the ethics of care try to conceptualize and address.

The ethics of care, as conceptualized by Eva Kittay (whose philosophical views on human rights were shaped by her mentally disabled daughter (Kittay, 2019; Wilson 2020), shares critical realism's position on the fundamental importance of care and dignity in our lives and that human dignity is intimately connected to care. (Kittay, 2011). Both theoretical approaches maintain that the foundations of human dignity should be looked for in the relationship humans bear to one another, foremost the relations based on care and deepest sense to be irreplaceable and inherently worthy, but not in attributions and any other factor (Kittay 2005, 111; Sayer, 2011). In other words, dignity is tied to being treated with moral concern and care (Sayer, 2011); the ability to give and receive care is a source of dignity for humans (Kittay 2011, 52). In this understanding, the intimate relationship between concern, care, and dignity creates universalistic conceptualization of dignity (Kittay, 2011; Sayer, 2011) that is distinct from narrow or conditional conceptualizations that focus on being "reasonable" or "capable" or possessing a certain quality beyond merely being human. Without universalistic understanding, the concept of human dignity becomes an empty notion.

As naturalistic conception maintains human rights are foremost moral rights that exist independently of any judicial decision only because one is a human being (Cruft et al., 2015, 1). Overall, human dignity is a "moral source" from which human rights ensue (Habermas, 2010). The primacy of ontology in critical realism (whereas in positivism and social constructivism, epistemology is primary) (Bhaskar & Hartwig, 2016) is compatible with the main idea of the naturalistic conception of human rights, which emphasizes the equal dignity of all human beings or the ontological/moral equality of human beings. In other words, critical realism's belief in ontological realism, especially transcendental realist ontology (Bhaskar & Hartwig, 2016), helps to understand and practically realize the equal ontological or moral dignity of human beings, the core idea of the universality of human rights. This conviction is important to overcome the relativist challenges in defending the universality of human rights. In other words, the acceptance of some absolute values through the naturalistic conception of human rights and critical realism can help to overcome the challenges brought about by relativism, among others, neoliberal capitalism relativistically challenges the fundamental values and principles.

As it is mentioned, human rights are validated by reference to the dignity of human beings, which is the value-based foundation of human rights (Hunt, 2007, 27; Erk, 2011). Not reason but empathy is a key to perceive the value of other people's lives and universality of human dignity fully. However, the concept of empathy played a marginal role in legitimizing universal human dignity, even in human rights studies (Hunt, 2007; Schultz, 2013). Nonetheless, a growing body of research has explored the intersection between emotions, human rights, and issues of justice. Specifically, research in the fields of psychology and neuroscience corroborates the role that emotions play in generating, shaping, and regulating the sense of justice and moral reasoning. (Loungo, 2021).

On the other hand, in its origins, "health system" was established not on claims or rights but on empathy, charity, kindness, and solidarity (Erk, 2011). Moreover, human beings come to health facilities because ill health makes them feel their worthiness, their dignity; that is the real reason they seek help and assistance (Meguid, 2016). Functional hospitals were not created by profit-seeking enterprises, but by institutions of religious charity, and the idea of health insurance initially was not a product offered by a profit seeking insurance companies but was invented by the pre-modern guild system based on mutual care (Erk, 2011).

Critical realist scholars argue that preserving so-called academic cool because of positivist epistemology leads to avoiding vulnerability and emotion on any account of social phenomena, so much of social theory and philosophy has a somewhat autistic and masculinist character (Sayer, 2017b). Also, a positivist tradition in social sciences, which attempts to avoid any engagement with normative debate by focusing only on a causal analysis and descriptive exploration, is unlikely to approach the problems of justice within a framework of human rights discourse (Turner, 1993).

Jonathan Wolff (2012), in his analysis of human right to health emphasizes the decades-long tendency of philosophers since 1948, the year when Universal Declaration of Human Rights (UDHR) was adopted, to view human rights doctrine as a marginal contribution to political philosophy or their tendency to argue about mere "aspirations". These weak foundations of the positivist human rights philosophy have had a negative effect on the development of human rights to health and health care (a main theme of this article).

3. The broad scopes of health and health care

Health is by nature a polysemous and dynamic concept (Breilh, 2021); the notions of health may differ from culture to culture (Porto et al., 2017) and change over time. The World Health Organization (WHO) initially defined health in its 1946 constitution as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (Constitution). This definition was truly groundbreaking at its time. This inclusive definition of health implies that health is not a separate concept from well-being (Breilh, 2021). Nonetheless, WHO's definition of health was criticized for various reasons (for being idealistic, static, and narrow, etc.).

As it is a dynamic concept, the notion of health has evolved over the last few decades. In our days, we can speak of various determinants of health such as biological, psychosocial, environmental, socio-economical, health-promoting behavior practices, medical advancement as well as ecological determinants (Li, 2017). This paper adopts the so-called broad understanding of health shaped by bio-psycho-social model. This comprehensive model, which views health as a dynamic interaction between biological, psychological, and social factors, was developed as an alternative to the conventional bio-medical model and was first formally conceptualized by psychiatrist Engel in 1977. According to the bio-psycho-social model, health is an interconnected system rather than an isolated state. Hence, health is a state of well-being that arises from the harmonious interaction of biological and psychological factors, supportive social relationships, and good environmental conditions rather than merely the absence of disease or infirmity (Engel, 1977). Moreover, it is important to see the intersectionality of inequity and the social determination of health rather than searching for the components that predispose disaffected groups to health threats, like exposure to COVID-19 showed (Raine et al. 2020).

On the other hand, due to the nexus between human, animal and ecosystem health, the collaborative, multi-sectoral, and trans-disciplinary approach of "One Health" was introduced in 2003–2004 (Prata et al., 2022). This approach that works at local, regional, national and global levels intends to achieve optimal health outcomes, taking into account the interconnection between humans, animals, plants and their shared environment (Prata et al., 2022).

Health care is different from health. Health care constitutes one of the three main pillars of social policy; the other two are education and social welfare (income) security. Health care policy aims to enhance the physical well-being of all population members, where children and elders are given particular focus. Health care is comprised of government decisions affecting the cost, delivery, quality, accessibility, and evaluation of programs conventionally funded through taxation. In a publicly funded health care system, the key delivery mechanisms are hospitals, health care professionals, and public expenditure. (McGregor, 2001, p. 82). In general, biomedical reductionism (normalized and sustained in the last decades by the domination of neoliberal capitalism in economy, politics and education) in the health-related issues and health care sector should be criticized in the context of social and ecological determinants of health.

Health care is indispensable for health and human life, to ease human suffering and serve human life by improving both the length and the happiness of human life. Health care has long been provided in various non-monetized forms, but it was only during the twentieth century that health care "rights" and "commodities" emerged in the sense in that they are used today (Gaffney, 2017).

On the other hand, health rights (as a concept is explored next) and health care are different notions, though they are closely interrelated. If health rights refer to a broader human rights concept (being grounded legally and ethically in international human rights law and in domestic legal systems of many countries), health care means tools or specific systems and services to enact health rights, foremost in the form of clinics, treatment,

medicines. Health care can be universally accessible or not (in private system). Human rights to health are violated in the presence of a high-quality health care system which is not accessible to those who cannot afford it (the case of the USA is an eloquent example, which is explored below).

4. Normative-legal grounds of the right to health

The human right to health is legally recognized in international human rights treaties; it is also protected by regional human rights laws and domestic law. (Hesselman & Toebes, 2015). The international and national legal regulations concerning health rights can show that law is pervasive, though not always visible. (Kaldor, et al., 2020). Theoretically, understanding health as a human right imposes a legal obligation on the states to ensure access to timely, appropriate and affordable health care of appropriate quality, as well as ensuring the relevant determinants of health, such as access to safe drinking water, provision of necessary sanitation, food, housing, health-related information and health education, finally gender equality". (Yaroshenko, et al. 2022, p. 250).

Article 25 of UDHR recognizes the right to an adequate standard of living, which includes the right to health and medical care. The International Covenant on Economic, Social and Cultural Rights (ICESCR) 1966 provides the most comprehensive article on the right to health in international human rights law. Article 12 formulates the right in a broad way as the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health"; the right to maternal, child and reproductive health; the right to healthy natural and workplace environments; the right to prevention, treatment and control of diseases; and the right to health facilities, good and services are stipulated (International Covenant, 1966).

General Comment No. 14, adopted in 2000 by the UN Committee on Economic, Social and Cultural Rights (UNCESCR) interprets the right to health as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, beyond preventive and curative health care to address underlying determinants of health beyond the health sector, including food, housing, work, education, non-discrimination, and equality. (E/C.12/2000/4: General Comment No. 14; Gostin, et al. 2018).

The right to health is recognized in International Convention on the Elimination of All Forms of Racial Discrimination (1969), Convention on the Elimination of All Forms of Discrimination against Women (1979) and Convention on the Rights of the Child (1989); Convention on the Rights of Persons with Disabilities (2007). Also, the regional legal systems of protection human rights, such as the European, the Inter-American and the African recognize the right to health.

While the European Social Charter recognizes the right to protection of health (Article 11), as well as the right to social and medical assistance (Dalli, 2018, p. 25), the European Convention on Human Rights premised on the idea to prioritize civil and political rights, hence it does not contain references to health care. In other words, the

European Court of Human Rights (ECtHR) decided to make a distinction between civil and political and social and economic rights, and it does not directly construe social rights such as the human right to health. (Catalán, 2022). However, right to health care was raised before the ECtHR, mainly in relation to Articles 2 (right to life) and 8 (right to respect for private and family life). (Marochini, 2013). Overall, it can be argued that the ECtHR is more inclined to use "integrated approach" in interpreting the Convention; moreover, the Court started giving some indications that it might to a degree include the right to health care into the European Convention on Human Rights. This position can be explained by the principle of the indivisibility of all human rights. (Marochini, 2013).

The decisions of international human rights courts are also important for understanding the development process of the right to health. In the case of Poblete Vilches and Others v. Chile, the Inter-American Court held for the first time that the respondent state had directly violated the right to health. The Court addressed General Comment 14 and the AAAQ standard of availability, accessibility, acceptability and quality. The Court focused on access to essential healthcare services, the guarantee of effective and high-quality medical care and the duty to improve general health conditions for the population. In its ruling, the Inter-American Court developed two rights. The first is the right to life and personal integrity of the elderly and the second is the right to health, especially for the elderly. In this case, the Court recognized for the first time the right to health as an autonomous right (Massa, et al. 2021).

The case of Mehmet Şentürk and Bekir Şentürk v. Turkey (2013) is considered in the context of Article 2 of the European Convention on Human Rights (the right to life). The Court found a violation of the fundamental right to life due to the failure of national law. While the element of personal negligence is relevant, in order to engage the State's international responsibility under Article 2, an unfit legal framework was required. (ECtHR, Mehmet Şentürk and Bekir Şentürk v. Turkey, April 9, 2013). Thus, the objective factor such as the inadequacy of the domestic legal system in protecting the right to health (with a reasonable connection to the protection of life) was a main reason why the ECtHR found the failure of the state. (Catalán, 2022).

Despite all the positive developments at the international (global, regional) and national level mentioned above, there are still problems which will be examined in the next section by considering the contested nature of the right to health. On the other hand, while law is an important determinant of health outcomes, it has so far been underutilized as a tool to improve global health. (Kaldor, et al., 2020).

5. The human right to health as an "incompletely conceptualized" and an "incomplete role" of the WHO

5.1. Understanding the human rights to health and health care

There are many different interpretations of the nature of the right to health. Conventionally, the right to health as a "fundamental human right" (ICESCR, General Comment No. 14) is based on the idea of "inherent dignity of the human person" (ICESCR,

Preamble, UDHR). An alternative position holds that it is "a moral right grounded in duty" or "a moral right derivative of the strict-sense human right to life but not dignity" (Erk, 2011, p. 308). However, an alternative position holds that health care should not be regarded as an individual human right. Moreover, according to this view, such a right does not currently exist in law and, if established, would lead to an expansion of government controls over health care, which would have a negative impact on efficiency and patient welfare (Goodman, 2005). Voluntary efforts based on partnerships, but not on legal mandates, should be created to expand access to health care. Hence, market-based mechanisms and incentives are more effective in ensuring innovation and access to health-related services. (Goodman, 2005).

The right to health can be understood as a "cluster of rights" (Dalli, 2018, p. 28). According to Flood and Gross (2014), the right to health is a social right recognized in the post-World War II international human rights order. In recent analysis Alvarez (2022) points out that right to health and health care have the status of customary international law; specifically, the right to health is defined as the economic, social, and cultural right of the individual to have a universal minimum standard of health without any discrimination. Also, recently Volker Turk (2024), UN High Commissioner for Human Rights, qualified the right to health as a fundamental human right, a duty held by all states under international human rights law. On the other hand, Gostin et al. (2018) noted that UDHR established a modern human rights foundation that has become a cornerstone of global health, central to public health policies, programs, and practices.

Some scholars perceive the human right to health as evolving collective right (see, Meier and Fox, 2013): this right is thought to have evolved from an "individual right of persons against a single governmental duty-bearer to a collective right of peoples against myriad duty-bearers throughout the world" (Meier and Fox, 2013, p. 61). The advocates of the global health law movement accept the right to health as an individual and collective human right. Global health law specifically points out that UDHR by establishing a human rights foundation under the UN became a cornerstone of global health. (Meier et al., 2023).

A more pragmatic position defines the right to health as a traditional socio-economic right, which has the status of an aspirational right with the main problematic issue being its non-justiciable character. (Marochini, 2013). Moreover, there is no universal definition of the right to health (also on the right to healthcare) and there has been significant disputation on the international and regional level regarding the nature of right to health. (Marochini, 2013). Therefore, Tobin indicated (2012), the right to health remains a relatively new concept, even within the medical profession and among public health professionals in general; moreover, some philosophers tend to disdain what they see as the weak philosophical foundations of the right to health in international law. Harrington and Stuttaford (2010) point out that for many, the idea of the right to health suffers from vagueness, incoherence, and incompleteness, especially when compared to more conceptual and established civil and political rights. The formal recognition of the right to health can be described as incomplete, although this process involves many institutions and reference documents (Marks, 2013).

The "incompletely conceptualized" nature of the human right to health is also due to the difficulties in developing social human rights (see, further in the section about the repercussions of neoliberal capitalism). For decades, the development of social rights was overshadowed by the focus on civil and political rights in many democratic countries and by most human rights organizations. Overall, the lack of theorization, insufficient legal tools or intellectual prejudice characterized the underdevelopment of social rights even in the realm of international human rights law (Catalán, 2022).

On the other hand, the right to health is characterized by weak mechanisms of domestic and international legal enforceability. According to comparative research, the enforceability of the right to health is different in different types of health systems. In high-income countries with tax-funded health systems there is an obvious lack of an enforceable right to health. In middle-income countries with big gaps between a poor public health system and a rich private one, it is more likely to find an express constitutional right to health care (or inferred from the right to life). (Flood & Gross, 2014). In some such as China and Hungary, with relatively well-functioning health care system, there is no judicial enforcement of health rights. In some other cases the approach of the judiciary is very modest and incremental, as in South Africa and India (Flood & Gross, 2014).

At the international level, particularly the mechanism of the ICESCR, which monitors the implementation of the right to health, is still weak. This mechanism is based on the individual complaint, which was only introduced in 2008 by the Optional Protocol to the ICESCR. It enables individuals and groups of individuals to send communications to the ICESCR in which they claim a violation of their economic, social and cultural rights. The Optional Protocol has only been ratified by thirty (out of 172) states by the end of 2024. However, 116 states have ratified the Optional Protocol to the ICCPR (View the ratification status). In general, states have been and still are reluctant to commit to social rights objectives, such as the right to health (Dally, 2018, p. 35).

Although the right to health was among the social and economic rights recognized in the post-World War Two human rights regime, it remained relatively dormant for about the first 50 years after its official recognition (Flood & Gross, 2014). This was largely due to the "incomplete role" of the WHO, which is analyzed below.

5.2. "Incomplete role" of WHO

In parallel to its inclusive definition of health, the human right to health was formulated by the WHO broadly, in line with the statement that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without distinction, including economic or social condition" (Constitution). In international law, however, the core formulation of the right to health has been defined in Article 12 of ICESCR, without explicit reference to social well-being, as "States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". In other words, despite the WHO's original inclusive definition, the right to health was used without the terms "complete" and "well-being" for further normative and practical elaborations (Marks, 2013). Under

the ideological antagonisms of the Cold War, opposition to socio-economic rights led to a narrow definition of the right to health and the determinants of health in the 1966 ICESCR. Only a limited set of steps were outlined to progressively realize this right. Even as democratic states continued to resist the expansion of a rights-based approach to health (Gostin et al. 2018).

In other words, in comparison with WHO's definition ICESC adopted more restricted definition because of the effects of the Cold War. The purpose of the ICESC can be interpreted in a way to include the reduction and elimination of poverty with the aim of defending the right to health. However, such an interpretative exercise is still challenging because neither the meaning of the right to health nor the methods for its interpretation are settled (Hunt 2016). Nonetheless, the advocates of global health law accept that article 12 of ICESCR is the most significant endorsement of a global right to health (Néill, 2021, p. 48).

Tobin (2012) notes that the theoretical account of the right to health reflects the nature of the agreement that state parties have reached under international law: "The text of the relevant international treaties reflects a moral commitment to the idea that health, or more precisely the highest attainable standard of health, is an interest worthy of recognition as an international human right" (Tobin, 2012, p. 50). However, the formulation and further elaboration of the right to health is generally a relatively recent phenomenon. As Harrington and Stuttaford (2010) argue, despite its rich historical background, the right to health was relegated into secondary status as a social right during the Cold War. Moreover, Meier (2010a) points out that despite its early support for promoting a human rights basis for its work, the WHO did not engage with the human rights discourse during the crucial years of the development and implementation of the right to health and became a technical organization that stood above "legal rights".

The WHO distanced itself almost entirely from its earlier commitment to international health rights; moreover, it actively refused involvement in the ongoing formulation of the right to health in international legal documents. (Gaffney, 2017, p. 135). Also, for decades WHO neglected broader social determinants of health or structural factors of negative health outcomes such as social and economic class, structural poverty. In the absence of WHO leadership for health rights, the human rights institutions of the UN — UNCESCR, and the Special Rapporteur on the Right to Health sought to interpret the right to health in an expansive manner that would set legal standards for addressing the underlying determinants of health (Meier, 2010b).

Declaration of Alma-Ata, adopted at the International Conference on Primary Health Care in 1978, was an attempt to develop a broad understanding of health. Right to health was reaffirmed as a fundamental human right and worldwide social goal (Declaration of Alma-Ata). According to Gostin et al. (2018) the right to health was reborn in this document. Declaration of Alma-Ata called for accessible, affordable, culturally appropriate and community-based health care (community participation in health planning and implementation). Primary health care was qualified as a means for creating equity. (Declaration of Alma-Ata). In addition to the promise to progressively

develop comprehensive health care systems embodied in the Health for All strategy, the Declaration affirmed access to basic health care services as a fundamental human right. However, this document lacked a normative anchor of sufficient weight (Hall & Taylor, 2003). Overall, Declaration of Alma-Ata can be seen as introducing paradigm shift and WHO tried to structure global health policy through this document.

The Declaration of Alma-Ata faltered in the early 1980s, with governments unable to promote national health systems amid neoliberal economic policies. In the end, because of the neoliberal restructuring policies the "Health for All by the Year 2000" in many countries was eroded into "health for those who can pay". The 2018 Astana Declaration, adopted in new capital city of Kazakhstan, renewed human rights pledges from the Declaration of Alma-Ata. It re-committed the states to strengthen primary health care as a cornerstone for achieving universal health coverage and health for all (Declaration of Astana).

Although the WHO played a central role in promoting health rights globally, it has failed for decades to establish health as a legally enforceable human right. On the other hand, the WHO issues non-binding decisions, declarations and guidelines that lack enforcement mechanisms. In the early 2000s, the UN ushered in a new era of human rights advancement and the WHO responded by developing a global health law. (Gostin, et al. 2018).

6. Repercussions of global advancement of neoliberal capitalism and "global problems" of health rights

Many problems concerning social justice and health-related inequalities in our days are generated by neoliberal capitalism, late twentieth-century incarnation of unregulated capitalism, which became associated with Thatcher, Reagan, Deng Xaioping, and 1989 Washington Consensus (Amadae, 2016). Its agreed-upon facets are as follows: all value is commodified and financialized; work and gradual wealth accumulation are replaced with speculation, risk management, and casino finance; ordinary citizens experience an increasing disparity in access to resources, income, and wealth. (Amadae, 2016).

In the turn of 2025, it can be argued that neoliberalism is trying to adapt to changing conditions and is mutating. On the other hand, neoliberal capitalism is also changing conditions because, like any complex social phenomenon, it is dynamic, transformative and hybrid. For example, we can argue about instrumentalization of human rights by neoliberalism or the entanglements between human rights and neoliberalism or an amalgamation of neoliberal logic with human rights in specific contexts transformed both concepts (Manfredi, 2018).

6.1. Neoliberalism's relativist challenge to human rights: erosion of empathy, social rights and justice

In the realm of values, neoliberalism accepts that economic values, especially the maximization of profit, are paramount in human life, as they supposedly only enhance the

value of freedom and legitimately increase general prosperity and well-being. Similarly, the ideologues of neoliberalism accept that the pursuit of collective (political) values not only interferes with individual freedom but also irrationally disrupts market rationality (Callison, 2019).

In the neoliberal understanding of values, self-centeredness and the preeminence of economic values determine all social, economic and political processes (see e.g. Freeman, 2015). Even if neoliberalism cannot adequately answer the question "What is the purpose of an economy?", wealth, profits and money-making are celebrated as ends in themselves (Sanghera & Satybaldieva, 2021, p. 281). Money becomes the medium for all values. Essential human faculties like solidarity and goodwill are invalidated (Amadae, 2016). However, the juxtaposition of individualism and social solidarity leads to the erosion of empathy (see below).

Neoliberal capitalism's belief in the "universality" of the market economy implies a relativist approach to the universality of human rights. Neoliberal ideologues regard "the expressions of human subjectivity as meaningless without the ratification by the market, they are nothing but relativism, each as good as any other" (Metcalf, 2017, online newspaper). Moreover, neoliberal "moral" truisms assert that "freedom is only possible in a market society" and "totalitarianism and redistribution inevitably go hand in hand" (see, Morefield, 2020; Whyte, 2019). Neoliberalism's logic contradicts the fundamental idea of the ontological equality of human beings, which is based on the idea of the universal dignity of humankind. All these can be seen as the relativist challenge to the universality and indivisibility of human rights, and the primary victim is social rights. Since the late 1980s, neoliberal capitalism has transformed the philosophy of the state, with its institutionalized commitment to social protection and justice, into a philosophy that protects the rentier classes, transnational corporations and big property owners against citizens demanding their rights.

On the other hand, the apathetic logic and cold rationality of neoliberalism, based on unconditional belief in a self-regulating market, is a socially learned "cultural prejudice" that undermines human capacities such as caring, empathy, solidarity and justice, and hardens the human personality. (Barreto, 2006). The neoliberal reforms became the manifestations of the deep erosion of empathy and justice. It was meaningful that one of the first neoliberal reforms exemplified the violation of the basic rights of the most vulnerable people. It was the decision of Reagan administration to deinstitutionalize patients in psychiatric hospitals in the United States, which resulted in approximately 140,000 mentally disabled people who were most in need of care and protection of their dignity being thrown out onto the streets across the country (Yamin, 2015, 20).

Neoliberal capitalism accepts disembedded from social needs economy as the central, defining feature of liberal democracy; moreover, it equalizes unregulated neoliberal capitalism and democracy (Onge, 2017). Hence, social programs and development of social rights based on solidarity principle was invalidated since welfare was pejoratively described by neoliberalism as parasitic (Sayer, 2018) and social policies were regarded as a sign of totalitarian mind (Whyte, 2019). However, the notion of human dignity protected

by social rights is fundamental to the welfare state and is increasingly accepted as an essential aspect of democratic society (Misztal, 2013). Moreover, the respect for universal human dignity distinguishes "genuine" democracy from "populist" pseudo-democracy (Zhussipbek, 2025).

The neoliberal agenda led to the reduction of the state's ability to comply with its positive human rights obligations. However, through the prism of the principle of solidarity, social rights are about ensuring a universal and egalitarian production of goods and services, which corresponds to the function of the socially responsible democratic system. (Catalán, 2022). The systemic injustice inherent in neoliberal capitalism leads to structural injustice, one of the reasons for the deterioration of the health of the population and the health system in recent decades and the high costs caused by the COVID-19 pandemic (Benach, 2021). The negative effects of neoliberalism on health are discussed below.

6.2. Neoliberal capitalism vs development of health rights

Neoliberal capitalism uses the narrowly defined concepts of health and the right to health to justify (in addition to belief in unregulated market's virtues) the privatization and commodification of health care. Even universal health care can be stripped of its "universal" meaning, although the "universal" moniker implies a fully public and equitable system. However, in a neoliberal context, it can be [mis-]used to provide health care depending on economic status (Gaffney, 2017, p. 219).

That the government's focus is shifted from ensuring access, quality, equity, and efficiency in the administration of public services to that of a profit-seeking business manager is one of the most pernicious effects of neoliberal privatization (Freudenberg, 2021), which could be felt most dramatically in the health care sector. The global financial institutions were the main actors in promoting neoliberal reforms in the health care sector (Waitzkin & Hellander, 2018). Being focused on austerity programs, shrinking the social protection, and the privatization of services related to health care, which were previously based in the public sector, neoliberal restructuring of the 1990s and early 2000s or the so-called health care reforms created different delivery mechanisms for health services by prioritizing market rules for-profit system over the common good, functionality over human well-being (McGregor, 2001, p. 82). These constitute fundamental difference from past or "conventional" private medical services (see, Gaffney, 2017).

Fundamental changes in economic philosophy led to the replacement of primary health care by "Health Sector Reform", based on market forces and the economic benefits of better health (Hall & Taylor, 2003). Thus, formerly universal systems were dismantled in favor of differential access, which violated the core principle of non-discrimination. (O'Connell, 2010). In general, the adverse effects of neoliberalization of the health care system can be seen in the serious destruction and chronic under-financing of the health care sector. In this regard the post-socialist countries, which used to have publicly funded, efficient, and robust health care systems, provide interesting example (see below, the case of Kazakhstan). If neoliberal policies do not reduce government health spending per se

(for example, reduction of spending is not the case in the USA, where the government health expenditures have increased sharply), they have been channeled through private companies and enriched them. In other words, neoliberal health care reforms were focused primarily on the privatization of services previously based in the public sector and on shifting public sector trust funds to private for-profit insurance corporations.

In general, neoliberal reforms negatively impacted health care systems in the countries that underwent neoliberal reforms (McGregor, 2001) and caused devastating impacts on physical and mental health of the population (Gaffney & Muntaner, 2018). Neoliberal capitalism leads to health inequalities, which are structural, but in essence avoidable, if appropriate mind-set is developed and policies are adopted. Privatization of health care resulted in a skewing of access, which favors the better-off in society, rather than the less-well-off, who often have more pressing health-related needs. (Harrington & Stuttaford, 2010, p. 10). Scott-Samuel et al. (2014) point out that due to neoliberal reforms the population of the UK became fundamentally less healthy. According to another recent research, the privatization of National Health Service in Italy made the population more vulnerable and unprepared to tackle COVID-19 Pandemic (Buzelli & Boyce, 2021).

The landmark research focused on the USA which analyzed more than 662 000 hospitalizations at 51 private equity-acquired hospitals found that in the three years after a private-equity acquisition, the rate of serious preventable medical complications increased significantly. (Kannan, et al., 2023). Overall, this comprehensive research concluded that emphasis on short-term material gains leads to cost cutting that is dangerous for patients (Kannan, et al., 2023). A 2018 report from the U.S. Government Accountability Office found that twice as many rural hospitals closed between 2013 and 2017 than in the previous five years, and that those that remained were in much worse financial shape than their non-rural counterparts. Rural hospital closures disproportionately occurred in the South, among for-profit hospitals, and among Medicare Dependent Hospitals. (Rural Hospitals, 2018).

Treating unwell individuals not as patients but as consumers for material gain and reducing government spending on health care creates the situation when the standard of care they receive will ultimately suffer. (Kennett, 2017). Neoliberal reforms gave a result of the reconstruction of the public sector health care system, retreat from universalism, increased cost-sharing, privatization, the commercialization and commodification of health care (Waitzkin, 2018, p. 16). The commodification of health care, which led to paradigm shift in health care sector, can be defined as the transformation of the interaction between a patient and caregiver from being deeply personal between people into an impersonal economic relationship. A patient is viewed as a buyer of care, and health care is turned into a thing or commodity that is bought and sold. Moreover, "instead of turning to a particular human being for care, patients are supposed to relate to a corporate institution, where doctors and nurses are interchangeable parts" (Himmelstein & Woolhandler, 2018, p. 57). The commodification of health care has downgraded the social and class position of health professionals. Because of the loss of control over their work process and a diminished ability to generate independent incomes, the medical profession has become "proletarianized." (Waitzkin, 2020).

The systemic negative effects of narrow understandings of health, normalized by neoliberal capitalism, range from abrogation of Health for All Strategy accepted by Declaration of Alma-Ata to the emergence of internally contradictory and "teeth-less" Universal Health Coverage, ambitious UN health policy goal to achieve health equity and social justice. Overall, neoliberal health care reforms led to increased inequality and poorer health outcomes worldwide, due to the systematic denial of access to health care. A narrow understanding of health (limited to bio-medical understanding) and right to health (limited to health care, which even under urgent needs may not be universally accessible) is a natural consequence of the overwhelming influence of neoliberal capitalism in many areas of life in recent decades (a more deeper analysis suggests that a narrow understanding of health is a consequence of reductionism in sciences shaped by positivist epistemology, for example, critical realist scholars hold that in the research on health and wellbeing, reductionism is expressed as the reduction of causality to a biophysical cause (Bhaskar et al., 2017). What is paradoxical is that the primary organization responsible for the protection of health rights, WHO, could not provide any serious resistance to the destruction of neoliberalism, moreover it became silently complacent in its global advancement.

6.3. The silent complacency of WHO to neoliberal "new normal"

Where WHO neglected human rights, it did so to the detriment of public health (Meier, 2010A, p. 2). Even though after twenty years of shunning human rights discourse, in 1978 WHO's public health leadership came to see human rights principles as a moral foundation upon which to frame WHO's Health for All strategy for primary health care — it was too late. The rise of neoliberal reforms in subsequent decades led in parallel to the normalization of the limited or bio-medical understanding of health (which is distant from the bio-psycho-social one, introduced by Engel) that focuses on vertical, narrow, curative interventions in the context of national health system retrenchment, reduced health expenditure, and widening health inequities. (Meier, 2010A, p. 47). In this context, WHO moved away from the comprehensive primary care approach and instead advocated vertical programs to treat disease and efficiency at the expense of equity (Emmel, 1998). Thus, WHO's initial inclusive definition of health turned out to be obscured because of neoliberal capitalism's inherent animosity to social policy. Overall, despite numerous efforts to develop a broad understanding of health, as expressed in the Health for All strategy, a limited understanding of the right to health emerged in the coming decades, interpreted predominantly as a right to health care, without taking into account the broader political and social factors.

In the 1990s, in the midst of health system reforms demanded by neoliberal agenda, WHO was viewed as an inept counter- voice, quite unable to communicate the central importance of primary health systems (Murphy, 2013, p. 28). Moreover, rather than opposing the neoliberal restructuring under the legal mantle of health rights, WHO fell victim to neoliberalism, forced into public-private partnerships for individual health care instead of primary health care for the public's health. (Meier, 2010A, p. 48).

Overall, the underlying motives of self-interest and national interest, as well as a lack of political will at the global and national levels, seriously contributed to the failure

of international organizations to make a concerted effort to conceptualize the broad definition of the right to health (Ruger, 2008). WHO accepted the medicalized view of health because international development agencies, driven by the larger "medical-industrial complex" and ignoring the social determinants of health, promoted the limited bio-medical understanding of health. This understanding prioritized the production and use of antibiotics, medical technologies, and the construction of private urban hospitals as a means to achieve economic growth (Meier, 2010a).

Nonetheless, WHO in the Bangkok Charter on Health Promotion in a Globalized World adopted in 2005, which can be seen as swing in a different direction, attempts to take again a more inclusive approach to health. (The Bangkok Charter). However, a more thorough analysis of this document suggests that the WHO has moved from a "new social movement discourse on eco-social justice" in the 1986 Ottawa Charter to a "new capitalist" discourse on law and economics (Porter, 2007). Although the content of the Bangkok Charter can be read as a response to "many global changes and trends that critically affect health and well-being," its discourse in reality helps to support many of them (Porter, 2007).

Overall, the weaknesses of WHO in the 1990s and early 2000s in developing rights-based approaches to health created insurmountable barriers to the development of the right to health (Meier, 2010b). The narrow definitions of health, based on a bio-medical understanding of health (which neoliberal capitalist min-set normalized) separate the concept of health from well-being. These definitions cannot carry value to the understanding of health in the context of the right to health (Marks, 2013, p. 6). The ineffective role of WHO seriously contributed to limiting the scope of the right to health to the instrumental and technical level.

6.4. Case studies of USA and Kazakhstan: the negative effects of neoliberal capitalism on health rights

The analysis of the US and Kazakhstan is interesting when it comes to understanding the impact of neoliberal capitalism on health rights. These two countries are very different, but they share one commonality — dominant in social policy neoliberal capitalism, which is directed against care, dignity, social solidarity and justice.

The US is the richest country in the world, but health care is the most expensive in the world, with significant structural health inequities. The country spends more than twice as much money on health care as other high-income countries, with worse outcomes (McClear, 2025). American health care system is extraordinarily unequal and fragmented, largely based on private insurance; hence principle of solidarity and decommodified health care are beyond rule. Overall, in American welfare and health law, the commitment to public care is generally contested and marginalized and health care is based on the political rejection of a collective response to the human need for care. Even the Affordable Care Act for vulnerable people stands as a weak statutory right to health care. In U.S. health law, the emphasis on meeting basic human needs has taken shallow root. (Emerson, 2021, p. 47). There is no universal health coverage; millions of people remain uninsured

or underinsured; access to healthcare is highly dependent on income, employment and government policy. Nearly one-third of Americans lack adequate access to primary care services; 40 percent of adults said they were delaying or forgoing doctor visits because of the high costs; more than one-third of all counties in the U.S. lack a single obstetrician or birthing facility (Why more Americans, 2023).

The case of Kazakhstan is interesting and important. Kazakhstan, whose largest city Almaty, was the birthplace of the Declaration of Alma-Ata (and in 2018, it was the home for the Declaration of Astana), is still struggling to achieve accessible and quality primary health care and truly "universal" universal health coverage. Although Kazakhstan's healthcare system is a legacy of the Soviet welfare model, it has been severely thinned out by IMF-imposed neoliberal reforms, leading to a catastrophic deterioration of health care in many regions. For example, the number of hospitals, especially in rural areas, fell by almost half, representing the largest decline in the region (Vang & Hajioff 2002, 161).

The institutionalization of the robust free primary health care system in Kazakhstan was hindered mainly by the neoliberal restructuring in recent decades and neoliberal mindset that still haunts Kazakh politicians, economists, and even public health professionals. The neoliberal institutions of public health care are geared towards neoliberal profit maximization. Because of a modest volume of government spending on health and education coming from "thin" social policy based on neoliberal ideology (Kazakhstan is the hydrocarbons rich country, 10th oil producer in the world with a small population), Kazakhstan was among the ten countries with the lowest level of healthcare funding in relation to GDP (Zhajetova, 2022). Reforms are underway but as of 2025, there is a partial universal health coverage characterized by neoliberal principles, many people are uninsured, paying out-of-pocket is high, people in rural areas and from vulnerable groups face structural barriers to their health rights.

7. Neoliberal mind-set and minimalism principle in legal systems

Law played a critical role throughout the 20th century to deliver safe and effective medicines and vaccines, to establish functioning health care systems, and to improve the built and natural environments. (Kaldor, et al., 2020). However, many of these social policy related phenomena came under assault with the global rise of neoliberal capitalism.

Concerning the right to health, the so-called principle of minimalism is adopted in many legal systems around the world; also, the minimalistic conceptualization of social rights is predominant in international human rights law (Catalán, 2022). In line with minimalism principle, the right to health has been largely understood as a minimum core of health care services aimed at subsistence or survival. The State complies with the right to health as set forth in Article 12 of the ICESCR as long as this minimum of services is provided irrespective of the way in which the provision of health care services is organized, public or private. (Catalán, 2022). This paper asserts that minimalism principle is allied with the narrow understanding of right to health normalized by neoliberal capitalism.

Judicial protection of health-related human rights can be a force for progressive change. However, the scholars who conducted comparative research in this area developed

more cautious positions (see, e.g. Flood & Gross, 2014). In fact, judicial protection of health rights addresses only the "tip of the iceberg," in a way that obscures the need for other strategies of systemic reform, or worse, may be co-opted in a way that exacerbates access issues. (Flood & Gross, 2014). In the countries with liberal democratic system (like the US and Canada) judicial protection of health rights led to the individualistic and often negative interpretation given to health rights. As a result, health rights can be interpreted as rights of non-interference, requiring only that the state not act rather than take positive action (Flood & Gross, 2014), which is against the principle of solidarism and cannot pave the way for developing full-fledged social human rights, including decommodification of health care. However, commodification of social rights like human rights to education and health endangers the universality and equality of social rights. On the other hand, minimalistic conceptualization of social rights, which is predominant in international human rights law makes conventional legal approach (Catalán, 2022) not very much sufficient for creating viable health rights.

Moreover, the litigation of health rights may undermine equality and reinforce privatization within established systems of universal health care like in Canada. Though what is needed is a more expansive judicial interpretation of existing constitutional rights to include a positive (publicly funded) right to health care; to date, the Canadian Supreme Court has been steadfast in its reluctance to do this. In the countries where health-related rights are given a positive interpretation, injustices can arise if limited public resources are diverted to those with the means and ability to litigate their right to health (Flood & Gross, 2014).

Concerning difficulties in determining the minimum core of the human right to health, Tasioulas (2017) notes that the potential discrepancy between international human rights law and constitutional law ought to be indicated. While international human rights law is intended to give legal recognition and effect to human rights, which are moral rights that we possess simply because of being human beings, constitutional rights are organized around the idea of rights we ought to possess as citizens of a given polity (Tasioulas, 2017). In this regards, Catalán (2022) notes that the development of human rights reflects that courts and legal scholars have mostly made themselves busy with finding the consequences civil rights have over social rights, and not so much vice versa. However, the indivisibility of human rights requires that human rights interpretation is, at the very least, something larger in scope than the interpretation of civil rights. Overall, it can be argued that until today judicial protection of health rights at the domestic/ national level has been only a partial solution because law can be interpreted differently, either from solidarity principle (see below) or principle of minimalism, suitable for neoliberal mind.

8. Non-inclusive Sustainable Development and "teeth-less" Universal Health Coverage

8.1. Criticism of Sustainable Development

The scholars at the Amsterdam School of Governance indicate that the concept of sustainability, as the UN defines it, hardly leads to actual "inclusive development" since it entails "perpetual economic growth", which is incompatible with "inclusion"

as a multifaceted ambition. Social inclusion of SDG fails without ecological inclusion, relational inclusion and relational betterment (the betterment of one group should not come at another group's expense) (Rammelt & Gupta, 2021; Gupta & Vegelin, 2016). However, inclusive development means a set of policies aimed at improving the social well-being of all segments of society and achieving environmental friendliness of development models. Inclusive development is about social inclusion, relational development and environmental inclusion, all of which are determinants of broadly understood health. (Gupta et al., 2015). Specifically, inclusive development aims to address not only social but also ecological and relational inclusion, with the latter aiming to ensure that the structural causes of inequality are also addressed (Obani & Gupta, 2017).

The COVID-19 Pandemic revealed the weaknesses of societal governance and underlying flaws and crises that were already present in the pre-pandemic global socio-economic system. (Gupta et al., 2021). The pandemic has shown that the SDG 3.3 and SDG 3.8 do not contain a conceptually sound analysis to address issues of social, environmental and relational inclusiveness, which lie beneath the multi-layered crisis. In other words, the concept of sustainability as defined by the UN gives in to the idea of growth for growth's sake and lacks relational development and relational inclusivity; it does entail any serious plan about systemic transformation of the global economy and post-growth development agenda. (Rammelt & Gupta, 2021). COVID-19 exposed and illuminated a number of underlying crises that were already inherent in the global political, economic-social and health system. (Gupta et al., 2021). Hence, sustainable development does not offer solutions which can change structural and systemic underpinnings of existing political, economic, social inequalities. It can be depicted as mere intra-paradigm alternative (or a version of capitalist economy-centric, "growth for the sake of growth", where human rights, including health rights, "coexist far too comfortably with neoliberal economic paradigms." (Yamin, 2015, p. 19).

To conclude, the notion of sustainable development may not provide systemic and paradigmatic criticism of hierarchical and anti-solidaristic capitalist morality. Also, SDGs can hardly develop viable human rights to health and health care because they are still non-inclusive.

8.2. Unfulfilled aim of UHC

One of WHO's major attempts to further develop the right to health was the goal of creating the Universal Health Coverage (UHC). UHC means that all individuals and communities receive the full range of quality health services they need without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the course of life. (Universal Health Coverage). However, UHC and universal access are not identical concepts. If UHC is about coverage and protection, universal access is about the real ability to get necessary care. A country can have UHC formally, but some people still cannot access care. Practical implementation of UHC can fail due to structural, political, social, cultural and economic-financial factors. In fact, universal access is about complete decommodification of health care as a result of implementation of solidarity principle (Catalán, 2022, see, further).

In 2015, the UN adopted Sustainable Development Goal (SDG) 3.3 (Control communicable diseases and epidemics and provide access to affordable essential medicines and vaccines) and SDG 3.8 (Achieve UHC worldwide by 2030) in health rights. The aim of creating UHC has risen to prominence in global debates. The 2019 UN Political Declaration on UHC, which states that "with a dedicated focus for the first time on universal health coverage", reaffirms the human right to health, which is "the right of every human being, without distinction of any kind". It also emphasizes that health is a precondition, an outcome and an indicator of the social, economic and environmental dimensions of sustainable development and the implementation of the 2030 Agenda for Sustainable Development (Political Declaration, 2019).

However, the strategy of the UN and WHO to develop UHC turned out to be teeth-less. As Health Policy Watch, the independent global health institution, notes in the post-pandemic period, there has been little progress in expanding universal UHC since the UN meeting on the issue in 2019. Furthermore, the trends in financial protection are even worsening, with catastrophic out-of-pocket spending increasing when compared to 2015. (Fletcher, 2023).

Regarding the discrepancy between the stated goals of creating UHC and the reality before and after the pandemic, WHO stated in October 2023 that "the world is off track to make significant progress towards UHC by 2030" (Universal Health Coverage). The improvements to health services coverage stagnated since 2015. The proportion of people who face catastrophic out-of-pocket health spending levels has steadily increased since 2000. This negative pattern is almost global; it is consistent across all regions and the majority of countries. (Universal Health Coverage).

Numerous obstacles to developing human rights to health and health care, for example, the slow progress, even stagnation of the creation of UHC, foremost in economically and technologically advanced countries, despite all the needs and urgencies revealed by the COVID-19 Pandemic, point to the systemic and structural problems inherent in neoliberal capitalism, which can be neutralized by adherence to solidarity principle and development of indivisibility of human rights.

This paper draws attention to the fact that while one pillar of UHC, provision of necessary health services, fully contributes to developing health rights, second pillar, the reliance on insurance coverage (it turned out to be private), by normalizing commodification of health care, curtails full-scale development of health rights (see, further about the need for decommodification). As Khoo (2015) notes, under sustainable development goals, UHC can be used to weaken one-tier universal systems and help legitimize and create two-tier systems, with increasing public ambivalence towards the principles of universality and solidarity in health care. For example, those European countries that could achieve equitable, rights-based universal coverage in earlier decades have experienced over two decades of reforms in the opposite direction. Responsibility was changed between the welfare state and the individual citizen (Khoo, 2015).

The shifting dynamics within UHC frameworks across different countries can be criticized because to make UHC achievable there is the need for a rights-based approach

that integrates solidarity and individual responsibility. However, this kind of integration within UHC tends to weaken the solidarity principle. Overall, UHC can be seen only as a partial return to an earlier transformative agenda for health equity and social justice under the banner of Primary Health Care (Khoo, 2015). On the other hand, SDGs fell short to develop decommodified understandings of health care based on solidarity principle, hence they are not sufficient to develop full-fledged rights to health and health.

The barriers to creating truly universal health care rose because of repercussions of neoliberal capitalism. The mental, structural (e.g. the inadequate funding and resource allocation primarily because of the direct and indirect effects of neoliberal reforms) and institutional (e.g. exemplified by the vested interests of primary actors in health care sector such as private insurers and pharmaceutical companies) obstacle are the main reasons for failure to achieve genuinely universal and decommodifed UHC. Successful implementation of UHC can be possible only under solidarity principle.

9. Suggestions for developing the full-fledged human rights to health and health care

This paper suggests that the recognizing and making health and health care full-fledged human rights require (1) systemic changes in political, economic and social systems; (2) cultural transformation and mental revival prioritizing care, empathy and dignity in our personal and social life (which is the most important factor); (3) realization of indivisibility of human rights and development of social rights, which are indispensable to protect human dignity; (4) implementation of solidaristic perspective leading to the complete decommodification of health care.

9.1. Systemic changes

Temporary measures like allocating funds to improve medical treatment or cash transfers, or the increase of salaries, cannot solve structural problems caused by neoliberalization of health care systems and transformation of the state and legal system by neoliberal capitalism. Reforms in health care systems to improve access to health care services or medicines will not remove the barriers to develop health rights, which stem from structural inequality, poverty, racism, social hierarchies, scarcity mindset, erosion of empathy caused by capitalism. A piece-meal approach to developing health rights may risk depoliticizing health issues, which can be found especially in conventional epidemiological studies (Porto et al. 2017, 112).

Tackling wide health inequalities requires concentration on a bold vision which unites health with justice. It demands fighting against structural inequalities, such as poverty, discrimination and violence, which are the root causes of ill-health; and it is a global project (Kaldor, et al., 2020). The right to health is dependent on and inextricably linked to a wide range of civil and political rights. (Yamin, 2008). Hence, the right to health is not just a juridical standard but a political means of resisting the effects of neoliberal capitalism in the health sector (Harrington & Stuttaford, 2010; O'Connell, 2010).

Without committed and accountable governments that are willing and, crucially, able to comply with their human rights obligations, the proliferation of human rights instruments and solemn declarations in the face of entrenched structural conditions conducive to the denial of human rights have no real meaning (O'Connell, 2007). Overall, we need the fundamental reappraisal of the current capitalist system, which means, among other things, the creation of an embedded economy in which economic processes are subjected to democratic control of society, something that no country has yet succeeded in doing. (Sanghera and Satybaldieva, 2021). This reorientation can only be achieved in the post-growth world with relational inclusion, socially responsible economic model, as inclusive development scholars propose. (Gupta et al., 2021).

The full-fledged development of human rights to health and health care demands philosophy and epistemology that connect welfare, economic and social rights and universalistic understanding of human dignity. This means the creation of a universal, generous welfare state with equal access for all citizens to vital social services and decommodified health care and education. All of these can be possible with the changes in the philosophy of the state, law and economy, what can be possible with mental change, cultural transformation (which is touched upon the next). Hence, if follow the logic of Putnam, mental or cultural transformation and moral revival should take place first, and only then will the economic, political and legal system change (Woodruff, 2025).

9.2. Cultural change and moral revival (revival of empathy and dignity)

Legal mechanisms and litigations are important in developing and supporting health rights. However, what is crucial is the worldview of those who work with law, who interpret the law. In adjudicating health rights, lawyers should scrutinize decision-making through the lens of health equity and equality to better achieve the inherent values of "health human rights" (Flood & Gross, 2014). For example, the exploration of the biographies of human rights lawyers, the advocates of health rights such as Alicia Yamin (2015), and Jonathan Mann, Lawrence Gostin, can show that they have internalized care, empathy and respect for equal moral dignity, solidarism. However, any good law and political decision can be re-interpreted and changed if there is a specific idea, or intention. The legal battles in the USA in 2025, when the Supreme Court's rules helped erode the checks on executive authority (e.g. Savage, 2025), also, the cases in Canada, when the litigation of health rights undermined equality and eroded the universal nature of universal health care (Flood & Gross, 2014) can prove this.

It is important to frame discussions about health rights and public health (also about the state, legal system, economy, security) by dwelling on the concepts of dignity, empathy and care, which are beyond conventional positivist approaches in social sciences, legal studies and "conventional normal" in academia, in general. In this sense, non-positivist epistemology may have more promises to develop health rights and human rights as a whole. A big claim of this paper is that the developing viable human rights to health and health care necessities cultural transformation and moral revival, conditioned by internalizing the primacy of care, concern, and dignity (understood in universalistic sense) in personal and

social life, as the assumptions of critical realism and ethics of care suggest. It necessitates going beyond positivist epistemology by accepting that emotions, values and reason are not contradictory, and that emotions and values are not beyond reason (Sayer, 2011). Overall, emotions imply real and universal structures of the human psyche that serve to evaluate the moral rightness of social interactions. They mediate our social interactions that inform others about what is valuable. (Loungo, 2021). For example, in legal field, empathy can play a significant role in the interpretation of constitutional rights (Corso, 2014).

This paper argues that critical realism may offer more empathetic and humane approach to develop human rights by offering non-positivist meta-theoretical approach, which can help revive empathy and dignity. Foremost, critical realist approach holds that our connection to the world is one concern, that dignity and care are what we need existentially, and that human intellect (reason) and emotions, values are not contradictory (Sayer, 2011). However, the positivist epistemology in understanding social phenomena tends to create lop-sided reason, moreover it is complacent to neoliberal capitalism's global spread (Barreto, 2006). On the other hand, critical realism provides the meta-theoretical framework to model how human rights function on multiple levels and help theorize the generative role of emotions at the most basic level. (Loungo, 2021).

Also, the ethics of care paves the way for solidaristic understanding of health rights (specifically health policy) and works to establish and maintain mutuality of respect and care between people and mitigates some key problems of legalistic ways of thinking of human rights (Emerson, 2021).

Also, mental transformation and moral revival helps find alternative pathways for moving out of human rights frameworks that coexist comfortably with neoliberal capitalism. This kind of substantial change is what Yamin (2015, p. 19) calls for – "if human rights-based approaches to health, and human rights frameworks more generally, are to fulfill their promise in changing the systems that perpetuate in equality and injustice, they must subvert entrenched and insulated institutions and what have become virtually hegemonic views of the world".

Conventionally, it is claimed that social rights are underdeveloped because they have budgetary implications and are financially demanding. It is important to find a balance between the legal obligations to develop the human right to health and the scarcity of resources. However, the main reason today is the neoliberal orthodoxy that leads to the idea of scarcity. As of 2012 at least thirty-two trillion dollars' worth of wealth (almost a third of the world's wealth) was held in tax havens and offshore zones (Super Rich, 2022). The world we live in therefore has an abundance of material and financial resources to develop social rights in general and health rights in particular. In other words, it is the mental, intellectual scarcity caused by the neoliberal capitalist mindset, which is an expression of the lack of care, empathy and respect for dignity —that prevents us from investing in social policies.

Moral revival and cultural change are the most viable way to resist the unethical and immoral principles of neoliberal capitalism that create a world of extreme inequalities

and where health and health care are tradable commodities and normalize life in such a world. Cultural transformation and moral revival bring about accepting that social rights are indispensable to protect human dignity and that a solidarity principle aimed at complete decommodification of health care are necessary, which are discussed in the next sections.

9.3. Reaffirmation of social rights as custodians of human dignity: embodiment of care and dignity in life

The human right to health can be legitimized by reference to universal human dignity or human right to life (Erk, 2011). This paper holds that legitimizing the right to health in dignity also supports this right from the side of social rights, because development of social and economic human rights is fundamental to protect human dignity. (Habermas, 2010). This is what has been missed in the neoliberal democracies that have paved the way for the creation of plutocracies instead of democracies (Sanghera and Satybaldieva, 2021). However, the key aim of social policy is to help restore or enable autonomy of human beings as far as possible, which is required by the dignity of those who benefit from social protection and help (Steigleder, 2014).

On the other hand, the purpose of public care is to provide individuals with the goods and services they need to exercise their agency. Agency and dignity are intimately connected. Right to health is one of those basic goods that enables people to define and advance their rights and interests. (Emerson, 2021).

The principle of indivisibility of human rights is overlooked in neoliberal and authoritarian contexts (not surprisingly, these two notions are intimately connected). Indivisibility of human rights can be overlooked even in the democratic welfare context. Moreover, a conventional legal approach, which is based on minimalism principle, hardly leads to developing robust health rights unless cultural or mental change takes place.

The fact that the system of the European Convention on Human Rights/ European Council's system is not supportive fully to accept human right to health care can show the degree of biased approach to social rights in this democratic context. (Catalán, 2022). Nonetheless, ECtHR started giving some indications that it might to a degree include the right to health care in the European Convention on Human Rights. This position can be explained by the principle of the indivisibility of all human rights. (Marochini, 2013). However, the progress in using integrated approach is dependent on the ability to resist neoliberal capitalism's effects in law, political and economic- social systems. Development of social rights based on the solidarity principle with the aims to ensure universal access to social goods and services (foremost, health care and education) means socialization of these services and their delivery through public institutions. (Catalán, 2022), which is touched next.

9.4. Implementation of solidarity principle and decommodification of health care

Health care practitioners (e.g. Gaffney & Muntaner, 2018) claim that a social human right to health care requires a universal public health system that provides health care as a social good, which is about the decommodification of health care. In other words,

without a universal public health system that is publicly owned and not shared by private enterprises, the full realization of health rights would be nearly impossible. The failure to realize UHC under the SDGs demonstrates this.

The integration and indivisibility of both sets of human rights, political and civil rights and social and economic rights is crucial in solidaristic conceptualization of the human right of access to healthcare. Attempts to develop a solidaristic definition of social rights should begin by challenging the public and private law divide. In other words, decommodification of social rights, specifically of health care, brings about questioning the public and private law divide in the context of the provision of health care services. (Catalán, 2022).

Decommodification means universality and equality for health care as proclaimed by human rights. Decommodification challenges the unequal market-based provision of services. (Catalán, 2022). In essence, in public care, especially in health rights, the government should orient official practice towards mutual aid and concern rather than the creation of a maximally efficient marketplace. (Emerson, 2021).

Theoretically, health rights are based on the principle of non-discrimination, which means that the enjoyment, especially of necessary health care, should be accessible to all groups, without distinction of economic class, social status, gender, and location (Yaroshenko, et al. 2022). Solidarity is against discrimination; non-discrimination is the indispensable feature of human rights as a concept. Non-discrimination requires decommodification because the market economy or market rules create barriers and hierarchies. However, legal systems demarcate and authorize the public and private division of health services, which means that commodification is normalized, thus payment for health services is the biggest barrier and the main source of the divide in today's neoliberal democracies. (Catalán, 2022).

Decommodification of health care system means full implementation of the provisions of UDHR (25 art), ICESCR (12 art), General Comment No. 14; Declaration of Alma-Ata. Hence, insurance-based systems are not capable of achieving this goal; in fact, they do not intend to achieve this goal. Only, solidarity principle-based decommodified health care systems can achieve the goal of the highest possible level of health. However, SD is at least silent about decommodification, though some critical evaluations imply the inherent problem of private-insurance logic in realizing UHC within SD model (e.g. Kaldor, et al., 2020; Khoo, 2015**)**.

Solidarity paves the way to different notion of social rights, which interprets them not as only "survival minimums" but in a sense of deeper egalitarianism where social rights are at the service of the liberty of all via decommodification (Catalán, 2022). Because of this, decommodified public good means community participation or citizens active involvement in their own health care decisions and systems (e.g. the Declaration of Alma-Ata called for citizens participation in health care systems). People's involvement in the decisions concerning health care is against privatization logic of neoliberal capitalism, whereas privatization cuts this nature of being public by making it private and turns citizens

into mere customers (Dorfman and Harel, 2016). Overall, health care system should nurture and enable the agency of the patient. It necessitates being public and to be based on the principle of solidarism or publicly funded, decommodified health care. Solidaristic perspective, which is based on decommodification, helps maximize the effectiveness and universality of social rights; hence it must be considered as necessary from the point of view of human rights protection (Catalán, 2022). And the work of the UNCESCR reflected a perspective that has recently gotten closer to solidarity. (Catalán, 2022).

The acceptance of the principle of solidarity, which aims to decommodify health care, does not imply opposition to a society with markets. There are some areas where markets are indispensable, but they are not universal and absolute. This paper attempts to show that market mechanisms cannot lead to good health outcomes (e.g. the cases in the US, UK, Italy and Kazakhstan mentioned in this paper) and that the countries that have embraced the neoliberal model of healthcare have had negative outcomes. In essence, treating human life and health as a source of money/profit maximization is immoral.

10. Conclusion

Health rights are among the main victims of neoliberal capitalism, which poses relativist challenge to equal moral dignity of human beings and the universality of human rights. The systemic problems in the development of social rights and the neglect of social justice are due to the persistence of capitalistic coldness and apathetic logic that influenced today's science, education, public perceptions, politics and legal culture. Making health and health care human rights is about understanding the primacy of care and dignity in our lives and social relations. Indeed, the UDHR (Article 25) connects the right to health to the right to live with dignity, which implies care, empathy and solidarity.

Human beings must not be seen as widgets to make money in the private equity world. Human rights should not be the hostages of allegedly "universal and natural" market rules. The human right to health can and should be a weapon against the structural injustice that forces so many of the world's poorest people into illness and premature death, and a political instrument to help combat global health crises as they inevitably arise (Muyskens, 2022, p. 99).

Making access to health care a human right, rather than a commodity allocated by market forces, is a fundamental challenge for 21st-century capitalism (Freudenberg, 2021). A human rights-based approach to health requires that health policies and programs prioritize the needs of those at the bottom of the road to justice (Yaroshenko, et al. 2022). There are enormous challenges when it comes to advancing health and social justice in today's world, and "human rights offer no easy, "magic bullet" solutions". (Yamin, 2015, p. 244). What can be called "conventional human rights approaches", based on a positivist epistemology, — cannot develop the understandings of health rights based on care and dignity, informed by a "solidarity" spirit and aiming to decommodify health care. There is a need for the conceptualization and development of truly inclusive human rights based on the uncompromising acceptance of the non-gradeable nature of human dignity, which is intimately connected to social rights. All of this can help to overcome the entanglements

between human rights, law and neoliberal capitalism and develop viable human rights to health and health care.

On the other hand, it is important to recognize the inherent flaws of the concept of SD and the SDGs. The SDGs are growth-oriented and not linked to relational development and relational inclusion. Therefore, for example, it is impossible to achieve true UHC as a policy goal if free, decommodified primary care is not institutionalized politically, legally and mentally, culturally. Moreover, the principle of the indivisibility of human rights requires the creation of decommodified health care.

To paraphrase Friedman et al. (2020), it is necessary to create a world where no one is left behind, whether in a health emergency or normal times. Although the equal global human right to health care is utopian-sounding, it is as defensible as any universal global human right (Gaffney, 2017, p. 219) within the conceptual framework of the universality of human rights substantiated by assumptions of the ethics of care, critical realism and other philosophies based on the idea of equal moral dignity of human beings —we owe each other as much as people with equal dignity (Yamin, 2015).

Funding

This article was prepared within the framework of the research grant of the Committee of Science, Ministry of Higher Education and Science of the Republic of Kazakhstan under the number AP19679071 entitled "Search for ways of building a just, human rights-centric, and strong Kazakhstan (social justice, inclusive identity, decoloniality)".

References

ALDERSON, P. (2016). 'The philosophy of critical realism and childhood studies', *Global Studies of Childhood, 6*(2), pp.199-210.

ALVAREZ J. E. (2022). 'The Missing Global Right to Health', *Proceedings of the ASIL Annual Meeting*, *116*, pp. 3-6. Cambridge University Press. https://doi.org/10.1017/amp.2023.3

AMADAE, S. (2016). *Prisoners of reason: Game theory and neoliberal political economy*. NY: Cambridge University.

BARRETO, J. (2006). 'Ethics of Emotions as Ethics of Human Rights: A Jurisprudence of Sympathy in Adorno, Horkheimer and Rorty', *Law Critique, 17*. https://doi.org/10.1007/s10978-006-0003-y

BENACH, J. (2021). 'We Must Take Advantage of This Pandemic to Make a Radical Social Change: The Coronavirus as a Global Health, Inequality, and Eco-Social Problem', *International Journal of Health Services*, *51*(1). https://doi.org/10.1177/0020731420946594

BHASKAR, R., DANERMARK, B. and PRICE, L. (2017). *Interdisciplinarity and Wellbeing: A Critical Realist General Theory of Interdisciplinarity*. London: Routledge

BHASKAR, R. and HARTWIG, M. (2016). *Enlightened Common Sense: The Philosophy of Critical Realism*. London: Routledge.

BREILH, J. (2021). *Critical Epidemiology and the People's Health*. Oxford University Press.

BUZELLI, M. and BOYCE, T. (2021). 'The Privatization of the Italian National Health System and its Impact on Health Emergency Preparedness and Response: The COVID-19 Case', *International Journal of Health Services, 51*(4), pp. 501-508.

CALLISON, W. (2019). *Political Deficits: The Dawn of Neoliberal Rationality and the Eclipse of Critical Theory*. Ph.D Dissertation, University of California, Berkeley. https://escholarship.org/uc/item/9p0574bc

CATALÁN, E. A. (2022). 'The right of access to healthcare: tracing solidarity in the United Nations, Inter-American and European human Rights systems, *European Society of International Law Paper- AEL 2022/01*, Academy of European Law.

Constitution of the World Health Organization. *Global Health and Human Rights*. Retrieved from: https://www.globalhealthrights.org/instrument/constitution-of-the-world-health-organization-who/

CORSO L. (2014). 'Should empathy Play any Role in the Interpretation of Constitutional Rights?' *Ratio Juris, 27*(1). https://doi.org/10.1111/RAJU.12037

CRUFT, R., LIAO, M. and RENZO, M, (2015). 'The Philosophical Foundations of Human Rights: An Overview', in R. Cruft, S. Liao and M. Renzo (eds.). *Philosophical Foundations of Human Rights.* Oxford: Oxford University Press.

DALLI, M. (2018). 'The human right to health: a retrospective analysis after 70 years of international recognition', *The Age of Human Rights Journal,* (11), pp. 24-42.

Declaration of Alma-Ata, WHO Europe. Retrieved from: https://iris.who.int/bitstream/handle/10665/347879/WHO-EURO-1978-3938-43697-61471-eng.pdf?sequence=1

Declaration of Astana, WHO's Global Conference on Primary Health Care in Astana, 2018.

DORFMAN, A. and HAREL, A. (2016). 'Against privatisation as such', *Oxford Journal of Legal Studies*, *36*(2), pp. 400-427.

ECtHR, Mehmet Şentürk and Bekir Şentürk v Turkey, 9 April 2013. Retrieved from: https://hudoc.echr.coe.int/eng#{%22itemid%22:[%22001-118722%22]}

E/C.12/2000/4: CESCR General Comment No. 14: The Right to the Highest Attainable Standard. Retrieved from: www.ohchr.org/sites/default/files/Documents/Issues/Women/WRGS/Health/GC14.pdf

EMERSON, B. (2021). 'Public Care in Public Law: Structure, Procedure, and Purpose', *Harv. L. & Pol'y Rev.*, *16*(35).

EMMEL, N. (1998). 'Health-for-All for 21st Century: Demise of Primary Health Care', *Economic and Political Weekly*, *33*(11). Retrieved from: http://www.jstor.org/stable/4406519

ENGEL, G. L. (1977). 'The need for a new medical model: a challenge for biomedicine', *Science*, *196* (4286), pp. 129–136.

ERK, CH. (2011). *Health, Rights and Dignity: Philosophical Reflections on an Alleged Human Right*. Ontos Verlag.

FLETCHER, E. (2023). 'UN Political Declaration on Universal Health Coverage: Ambitious Aspirations Against Litany of Failures', *Health Policy Watch.* September 15. Retrieved from: https://healthpolicy-watch.news/un-political-declaration-on-universal-health-coverage-ambitious-reach-against-autopsy-of-failures-to-date/

FLOOD, C. M. and GROSS, A. (2014). 'Litigating the right to health: What can we learn from a comparative law and health care systems approach', *Health and Human Rights*, *16*, 62.

FREEMAN, M. (2015). 'Neoliberal Policies and Human Rights', *Dokuz Eylül Üniversitesi Hukuk Fakültesi Dergisi*, 17(2). https://dergipark.org.tr/en/download/article-file/753653

FREUDENBERG, N. (2021). *At What Cost: Modern Capitalism and the Future of Health*. Oxford: Oxford University Press.

FRIEDMAN, E. et al. (2020). 'Global Health in the age of COVID-19: responsive health systems through a right to health fund', *Health and human rights*, 22 (1), 199.

GAFFNEY, A. (2017). *To Heal Humankind: The Right to Health in History*. NY: Routledge.

GAFFNEY, A. and MUNTANER, C. (2018). 'Austerity and health care', in H. Waitzkin and Working Group for Health Beyond Capitalism (eds.) *Health Care under the Knife: Moving beyond Capitalism for Our Health* (pp.119-135). NY: Monthly Review Press.

GOODMAN, T. (2005). 'Is there a right to health?' *The Journal of medicine and philosophy*, *30*(6), pp. 643-662.

GOSTIN, L. O., MEIER, B. M., THOMAS, R., MAGAR, V. and GHEBREYESUS, T. A. (2018). '70 years of human rights in global health: drawing on a contentious past to secure a hopeful future', *The Lancet*, *392*(10165), pp. 2731-2735.

GUPTA, J., BAVINCK, M., ROS-TONEN, M., ASUBONTENG, K. et al. (2021). 'COVID-19, poverty and inclusive development', *World Development, 145*, 105527.

GUPTA, J., POUW, N. and ROS-TONEN, A. (2015). 'Towards an Elaborated Theory of Inclusive Development', *European Journal of Development Research*, *27*(4).

GUPTA, J. and VEGELIN, C. (2016). 'Sustainable development goals and inclusive development', *International environmental agreements,* 16, pp. 433-448.

HABERMAS, J. (2010). 'The concept of human dignity and the realistic utopia of human rights', *Metaphilosophy, 41*(4), pp. 464–80.

HALL, J. and TAYLOR, R. (2003). 'Health for all beyond 2000: the demise of the Alma-Ata Declaration and primary health care in developing countries', *The Medical Journal of Australia, 178*(1), pp. 17-20.

HARRINGTON, J. and STUTTAFORD, M. (2010). 'Introduction', in J. Harrington and M. Stuttaford (eds.) *Global health and human rights: legal and philosophical perspectives* (pp. 1-12). NY: Routledge.

HESSELMAN, M. and TOEBES, B. (2015). 'The human right to health and climate change: a legal perspective. Input to the study of the OHCHR pursuant to HRC Resolution 29/15 31', *Global Health Law Groningen Working Paper*. Groningen University.

HIMMELSTEIN, D. and WOOLHANDLER, S. (2018). 'The political economy of health reform', in H. Waitzkin and Working Group for Health Beyond Capitalism (eds.), *Health Care under the Knife: Moving beyond Capitalism for Our Health* (pp. 57-68). NY: Monthly Review Press.

HUNT, L. (2007). I*nventing Human Rights. History*. NY: W. Norton.

HUNT, P. (2016). 'Interpreting the international right to health in a human rights-based approach to health', *Health and Human Rights*, *18*(2), pp. 109-130.

International Covenant on Economic, Soial and Cultural Rights, 1966. UN Human Rights, Office of The High Commissioner. Retrieved from: www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights

ISSEL, L. (2014). 'It's health care, not healthcare', *Health Care Manage Rev*., *39*(4), https://doi.org/10.1097/HMR.0000000000000040

JUNG, C., HIRSCHL, R. and ROSEVEAR, E. (2014). 'Economic and social rights in national constitutions', *The American Journal of Comparative Law*, *62*(4), pp. 1043-1094.

KALDOR, J. C., GOSTIN, L. O., MONAHAN, J. T. and GOTTSCHALK, K. (2020). 'The Lancet–O'Neill Institute/Georgetown University Commission on global health and law: The power of law to advance the right to health', *Public Health Ethics*, *13*(1), pp. 9-15

KANNAN, S., BRUCH, J. and SONG, Z. (2023). 'Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition', *JAMA*. *330*(24), pp. 2365–2375. https://doi.org/10.1001/jama.2023.23147

KENNETT, J. (2017). 'Examining Neoliberalism and Mental Health Strategy — A Discursive Analysis of a UK Department of Health Document'. *MMU Psychology Journal (Dissertations)*. Manchester Metropolitan University. https://e-space.mmu.ac.uk/619203/

KHOO, E. J. and LANTOS, J. D. (2020). 'Lessons learned from the COVID-19 pandemic', *Acta Paediatrica*, *109*(7), pp. 1323-1325. https://doi.org/10.1111/apa.15307

KHOO, S.-M. (2015). 'Solidarity, equity and rights-based to health provision', *Commonwealth Health Partnerships -2015*. Commonwealth Secretariat. https://doi.org/http://hdl.handle.net/10379/6790

KITTAY, E. (2005). 'Equality, Dignity and Disability', in M. Waldron and F. Lyons (eds.). *Perspectives on Equality: The Second Seamus Heaney Lectures*. Dublin: Liffey.

KITTAY, E. (2011). 'The Ethics of Care, Dependence, and Disability'. *Ratio Juris*, *24*(1).

KITTAY, E. (2019). *Learning from my daughter: The value and care of disabled minds*. Oxford University Press.

LI, A. M. (2017). 'Ecological determinants of health: food and environment on human health', *Environmental Science and Pollution Research, 24*(10), pp. 9002-9015.

LUONGO, B. (2021). 'Critical Realism, Human Rights, and Emotion: How an Emotive Ontology Can Resolve the Tensions Between Universalism and Relativism', *Human Rights Review*, *22*(2), pp. 217-238.

MANFREDI, Z. (2018). 'An unlikely resonance? Subjects of human rights and subjects of human capital reconsidered', in B. Golder, D. McLoughlin (eds.). *The Politics of Legality in a Neoliberal Age*. NY: Routledge.

MARKS, S. (2013). 'The emergence and scope of the human right to health', in S. Marks, J. Zuniga and L. Gostin (eds.). *Advancing the human right to health* (pp. 3-24). Oxford: Oxford University Press.

MAROCHINI, M. (2013). 'Council of Europe and the right to healthcare-is the European Convention on Human Rights appropriate instrument for protecting the right to healthcare?' *Zbornik Pravnog fakulteta Sveučilišta u Rijeci*, *34*(2), 729-760.

MASSA, A. A., VILLOUTA, M. B. and FERRADA, C. R. (2021). 'Sanctioning Chile's public health care system for not providing basic services to the elderly: The Inter-American Court's Poblete Vilches Ruling'. *Health and Human Rights, 23*(1), 251.

MCCLEAR, S. (2025). 'The Perilous Spread of the Wellness Craze', *The Atlantic*, May 29. Retrieved from: https://www.theatlantic.com/books/archive/2025/05/how-health-became-luxury-commodity/682957/

MCGREGOR, S. (2001). 'Neoliberalism and health care', *Int J Consum Stud*, *25*(2), pp. 82-89.

MEGUID, T. (2016). '(Re)Humanising Health Care – Placing Dignity and Agency of the Patient at the Centre', *Nordic Journal of Human Rights*, *34*(1), pp. 60-64. https://doi.org/10.1080/18918131.2016.1153189

MEIER, B. et al. (2023). 'A critical juncture for human rights in global health: Strengthening human rights through global health law reforms', *PLOS Glob Public Health, 3*(12). https://doi.org/10.1371/journal.pgph.0002663

MEIER, B. (2010a). 'Global health governance and the contentious politics of human rights: Mainstreaming the right to health for public health advancement', *Stanford*

Journal of International Law, *46*(1), pp. 1-50. https://bmeier.web.unc.edu/wp-content/uploads/sites/700/2011/08/Meier-2010-2.pdf

MEIER, B. (2010b). 'The World Health Organisation, the Evolution of Human Rights and the Failure to Achieve Health', in J. Harrington and M. Stuttaford (eds.). *Global health and human rights: legal and philosophical perspectives*. NY: Routledge.

MEIER, B. M. and FOX, A. M. (2013). International obligations through collective rights: Moving from foreign health assistance to global health governance. *Health & Hum. Rts.*, *12*, 61.

METCALF, S. (2017). 'Neoliberalism: the idea that swallowed the world'. *Guardian*, August 18. https://www.theguardian.com/news/2017/aug/18/neoliberalism-the-idea-that-changed-the-world

MISZTAL, B. (2013). 'The idea of dignity: Its modern significance', *European Journal of Social Theory, 16*(1), pp. 101-121.

MOREFIELD, J. (2020). 'When Neoliberalism Hijacked Human Rights', *Jacobin*, May 1. https://www.jacobinmag.com/2020/01/morals-markets-human-rights-rise-neoliberalism-jessica-whyte

MURPHY, T. (2013). *Health and human rights*. Oxford: Hart publishing.

MUYSKENS, K. (2022). 'A Human Right to What Kind of Health?', *Ethics and Social Welfare*, *16*(4), pp. 364-379.

NÉILL, CÓ. (2021). 'A global right to health amid global health emergencies', in CÓ. Néill, et al. (eds.) *Routledge Handbook of Global Health Rights*. (pp. 47-61). NY: Routledge.

OBANI, P. and J. GUPTA. (2017). 'Inclusive development as an imperative to realizing the human right to water and sanitation', *Journal of Sustainable Development Law and Policy, 8*(2), pp. 67-86.

O'CONNELL, P. (2007). 'On reconciling irreconcilables: Neo-liberal globalisation and human rights', *Human Rights Law Review*, *7*(3), pp. 483-509.

O'CONNELL, P. (2010). 'The human right to health in an age of market hegemony', in J. Harrington and M. Stuttaford (eds.) *Global health and human rights: legal and philosophical perspectives (*pp.190-210). NY: Routledge.

ONGE, J. (2017). 'Neoliberalism as Common Sense in Barack Obama's Health Care Rhetoric', *Rhetoric Society Quarterly*, *47*(4).

POBLETE VILCHES and OTHERS V CHILE (Merits, Reparations and Costs) Inter-American Court of Human Rights, 2018. March 8. https://www.escr-net.org/caselaw/2019/poblete-vilches-and-others-v-chile/

Political Declaration of the High-level Meeting on Universal Health Coverage, 2019. Retrieved from: https://www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf

PORTER, C. (2007). 'Ottawa to Bangkok: changing health promotion discourse', *Health Promot Int*.; *22*(1), pp. 72-79. https://doi.org/10.1093/HEAPRO/DAL037

PORTO, M., FERREIRA, D. and FINAMORE, R. (2017). 'Health as dignity: political ecology, epistemology and challenges to environmental justice movements', *Journal of Political Ecology*, *24*(1), pp. 110-124.

PRATA, J., RIBEIRO, A. and ROCHA-SANTOS, T. (2022). 'An introduction to the concept of One Health', in Joana C. Prata, Ana Isabel Ribeiro, Teresa Rocha-Santos (eds). *One Health* (pp. 1-31). Academic Press.

RAINE, S., LIU, A., MINTZ, J., WAHOOD, W., HUNTLEY, K. and HAFFIZULLA, F. (2020). 'Racial and Ethnic Disparities in COVID-19 Outcomes: Social Determination of Health', *International Journal of Environmental Research and Public Health*, *17*(21).

RAMMELT, C. and GUPTA J. (2021). 'Inclusive is not an adjective, it transforms development: A post-growth interpretation of Inclusive Development', *Environmental Science & Policy, 124*, pp. 144-155. https://www.sciencedirect.com/science/article/pii/S1462901121001726

RUGER, J. (2008). 'Normative foundations of global health law', *Georgetown Law Journal*, *96*(2).

Rural Hospital Closures: Number and Characteristics of Affected Hospitals and Contributing Factors (2018). GAO-18-634, August 29. Retrieved from: https://www.gao.gov/products/gao-18-634

SANGHERA, B. and SATYBALDIEVA E. (2021). *Rentier Capitalism and Its Discontents*. Cham: Springer International Publishing.

SAVAGE, C. (2025). 'With Supreme Court Ruling, Another Check on Trump's Power Fades', *New York Times*, June 28. https://www.nytimes.com/2025/06/28/us/supreme-court-trump-executive-branch-power.html

SAYER, A. (2011). *Why things matter to people: social science, values and ethical life*. Cambridge: Cambridge University Press.

SAYER, A. (2017a). 'Values within reason', *Canadian Review of Sociology*, *54*(4), pp. 468-475.

SAYER, A. (2017b). 'Critique and naturalism'. In U. Lindner and D. Mader (Eds.), *Critical Realism Meets Kritische-Theorie* (pp. 315-337). Bielefeld: Transcript Verlag.

SAYER, A. (2018). 'Welfare and moral economy', *Ethics and Social Welfare*, *12*(1), pp. 20-33, https://doi.org/10.1080/17496535.2017.1377273

SCHULTZ, N. (2013). *Empathy as the key to equality and human rights: an investigation of empathy's role in inter-group relations and discrimination. Doctoral Dissertation*. Poznan: Adam Mickiewicz University. https://repository.gchumanrights.org/handle/20.500.11825/643

SCOTT-SAMUEL, A., BAMBRA, C., et al. (2014). 'The impact of Thatcherism on health and well-being in Britain', *International Journal of Health Services*, *44*(1), pp. 53-71.

STEIGLEDER, K. (2014). 'Human Dignity and Social Welfare'. In M. Düwell, et al. (Eds.), *The Cambridge Handbook of Human Dignity: Interdisciplinary Perspectives* (pp. 471–76). Cambridge: Cambridge University Press.

SUPER RICH HOLD $32 TRILLION IN OFFSHORE HAVENS (2022). Reuters. July 22. Retrieved from: https://www.reuters.com/article/business/super-rich-hold-32-trillion-in-offshore-havens-idUSBRE86L03V/

TASIOULAS, J. (2017). 'Minimum core obligations: Human rights in the here and now'. World Bank. Retrieved from: http://hdl.handle.net/10986/29144 License

THE BANGKOK CHARTER FOR HEALTH PROMOTION IN A GLOBALIZED WORLD (2005). World Health Organization. Retrieved from: https://www.who.int/teams/health-promotion/enhanced-wellbeing/sixth-global-conference/the-bangkok-charter

TOBIN, J. (2012). *The Right to Health in International Law*. Oxford: Oxford University Press.

TURK, V. (2024). 'Revitalising the right to health is essential to securing better health for all', *The Lancet, 403*(10434), pp. 1315-1318.

TURNER, B. S. (1993). 'Outline of a theory of human rights', *Sociology*, *27*(3), pp. 489-512.

UNIVERSAL HEALTH COVERAGE (2025). World Health Organization, 26 March. Retrieved from: https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)

VANG, J. and S. HAJIOFF. (2002). 'Rationalizing hospital services', in M. McKee, J. Healy and J. Falkingham (eds.). *Health care in Central Asia.* Buckingham: Open University Press.

View the ratification status by country or by treaty, United Nations Human Rights Treaty Bodies. Retrieved from: https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?Treaty=CCPR&Lang=en

WAITZKIN, H. (2018). 'Introduction: What We're Trying to Do Here and Why?', in: H. Waitzkin and Working Group for Health Beyond Capitalism (eds), *Health Care under the Knife: Moving beyond Capitalism for Our Health*. NY: Monthly Review Press.

WAITZKIN, H. (2020). 'Moving beyond capitalism for our health', *International Journal of Health Services*, *50*(4), pp. 458-462.

WAITZKIN, H. (2021). 'COVID-19 as Cause versus Trigger for the Collapse of Capitalism', *International Journal of Health Services*, *51*(2). https://doi.org/10.1177/0020731420977711

Why more Americans are putting off going to the doctor (2023). *PBS Weekend,* March 25. Retrieved from: https://www.pbs.org/newshour/show/why-more-americans-are-putting-off-going-to-the-doctor

WHYTE, J. (2019). *The Morals of the Market: Human Rights and the Rise of Neoliberalism*. London: Verso Books.

WILSON, R. (2020). Learning from Daughter. E*thics of Care.* https://ethicsofcare.org/learning-from-my-daughter/

WOLFF, J. (2012, June). 'I—The Demands of the Human Right to Health', *Aristotelian Society Supplementary Volume,* Blackwell Publishing, *86*(1), pp. 217-237.

WOODRUFF, J. (2025). Robert Putnam reflects on how America became so polarized and what can unify the nation. *PBS News*, February 19. Retrieved from: https://www.pbs.org/newshour/show/robert-putnam-reflects-on-how-america-became-so-polarized-and-what-can-unify-the-nation

YAMIN, A. (2008). Will We Take Suffering Seriously? Reflections on What Applying a Human Rights Framework to Heath Means and Why We Should Care', *Health & Human Rights*, *10*(1), pp. 45-63.

YAMIN, A. (2015). *Power, suffering, and the struggle for dignity: Human rights frameworks for health and why they matter*. University of Pennsylvania Press.

YAROSHENKO, O., STESHENKO, V., TARASOV, O., NURULLAIEV, I. and SHVARTSEVA, M. (2022). Right to health care: the practice of the ECTHR and the case of Ukraine. *The Age of Human Rights Journal*, (18), pp. 239-256.

ZHAJETOVA, Z. (2022). 'Za chto my platim i pochemu OSMS ne garantiruyet kazakhstantsam kachestvennoy meditsinskoy pomoshchi'. *Informburo*, July 26. Retrieved from: https://informburo.kz/interview/za-cto-my-platim-i-pocemu-osms-ne-garantiruet-kazaxstancam-kacestvennoi-medicinskoi-pomoshhi-mnenie-eksperta

ZHUSSIPBEK, G. (2025). If human rights are ignored, democracy becomes a plaything for populists, TEDxAstana Salon. www.youtube.com/watch?v=-Ib7poU4CT4&t=1s

Received: 24th October 2024
Accepted: 5th September 2025