

# The role of research in the right to health and the universal provision of health care

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## Introduction

It is common for governments to promise universal health care coverage during electoral campaigns; indeed, it is something that hardly anyone could not aim for.

Research can play a major role in the evaluation of health systems. Research thus contributes to the public debate regarding the health and wellness effects of different systems as well as the degree to which different systems realize the universal right to health.<sup>1</sup> Research can be used both by policymakers concerned with achieving effective coverage as well as by social movements interested in fostering public debate and social mobilization to demand governmental enforcement and protection of the universal right to health enshrined in international human rights law.<sup>2</sup>

## The Latin American experience with universal health care access

In many Latin American countries, health systems and health policies have tended to copy foreign models and do not adequately address the local national context. There are some exceptions, most notably Cuba. Foreign models are imposed either by very powerful foreign governments or through the demands of international funding agencies. Local elites then go along.

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After World War II – and under pressure from national workers’ parties – most Latin American governments adopted the Bismarckian model used in many European countries; social insurance coverage was responsible population health policy. However, this scheme was not really appropriate in the Latin American context, which is characterized by a majority rural population, low industrialization, and many employed in the informal sector. These health systems also included a public sector that provided care for the poor and a private sector for those who could pay. The result was a fragmented health care system; the industrial workers and employees (public and private) had health insurance through social security, the poor went to the public sector, and the well-off used private doctors and clinics, leaving large sectors of the population without effective health coverage.

In the early 1990s, the World Bank and the International Monetary Fund encouraged Latin American governments to adopt “social security reform.” In fact, this reform was a requirement by the World Bank as a condition for refinancing foreign debt. It imposed a neoliberal social security model based on individual health care insurance and the private provision of care.<sup>3</sup>

This model of social coverage increased funding for health services (most of which went to private sector) and expanded the percentage of people insured. But it also created a series of economic, administrative, and informational barriers that resulted in extensive restrictions on the actual use of health care services. Large segments of the population were left without real health care coverage.<sup>4,5,6</sup>

Only those countries in the region which have chosen universal social security systems (Costa Rica) or national health systems (Brazil and Cuba)<sup>7</sup>

have made effective progress in providing health care access to their entire population. In contrast, countries like Colombia, which have achieved universal health insurance, still provide only limited real access to health services.<sup>5,8</sup>

Despite their diversity, most Latin American health systems still do not guarantee the right to health in actual practice. Latin American health systems on one hand remain fragmented and inequitable and on the other emphasize private access to disease-focused care,<sup>5,9</sup> ignoring fundamental aspects of the right to health and its social determinants: food, basic sanitation, housing, work safety and dignity, and the political participation of individuals.

### **The universal right to health and to effective access to health care, beyond universal “disease” care insurance**

Most health systems research has addressed the issue of coverage of health care services (more precisely, taking care of diseases). This, however, is only one part of the guarantee of the right to health.

Health systems research also needs to examine how health systems and policies can guarantee non-discrimination in access to institutions, services, policies, and programs that positively affect well-being and quality of life and impact the social determinants of health. This is far more than simply providing health insurance for curative services or developing a “basic package” of limited services targeted for the poor.<sup>4,5</sup> In essence, we need research on how to implement the fundamental ideals of 1978 Alma Ata Declaration.

The adoption of a human rights perspective implies accepting that the State is guarantor of the right to health. It also presupposes that civil society is organized and mobilized to demand this right through social, political, and legal means; these means include the use of health systems research.<sup>10,11</sup>

### **Researching the outcomes of health systems and policies**

Undoubtedly research can play a key role in designing public policy that provides the maximum benefit for public health. Research has an impact on

policies through its influence on conceptual frameworks, policy implementation, community involvement, health systems management, health practices, and intersectoral initiatives.<sup>12</sup> It is important, however, to recognize that research is subject to biases related to funding sources and/or the theoretical and academic orientation of the investigators.<sup>13,14,15</sup>

The health systems research funded by international organizations or private corporations typically supports market-driven models and ignores consideration of health as a right. This type of research legitimates health policy approaches that focus on the poorest sectors; the project of universalism and equity is abandoned.

Independent critical research on health policy is far scarcer; it has few financial backers and more restricted outlets for publication. Such research, however, has demonstrated the negative health outcomes associated with market-driven systems. Markets are quite limited as a way of achieving universal access to health care. Critical research suggests that public systems are the best choice for promoting this goal.<sup>5,16,17,18</sup>

Critical research in Latin America has fostered collaborations between academics and communities using the Participatory Action-Research model (Investigación-Acción-Participativa [IAP]).<sup>19</sup> These studies have exposed the daily barriers that keep people from accessing quality health care that is both high quality, timely, and humane.<sup>20-23</sup> This type of research was designed specifically to generate knowledge that would support social action, in support of social change. Research develops within the community, makes a political commitment to foster change, and turns citizens into political subjects who are themselves capable of enforcing the right to health (using legal, social and political means).

It should be clear by now that health research is an arena for political disputes.<sup>24</sup> Wealthier sectors are more likely to legitimize models that serve their interests and policies that are pro-privatization and that impact negatively on population health. In general, academic and social sectors are critical of this approach and demand real reforms that make the universality of the right to health a reality

Health research – given its social nature – is influenced by ideology. The general political and ethi-

cal context influences the very conduct of research, the interpretation of results, and the capacity of research findings to impact on public policies. Research is not neutral. Researchers express their own ways of seeing and interpreting the world.<sup>25,26</sup> Funding agencies influence what gets investigated and what results are obtained. Policymakers can choose to adopt or ignore research findings. Those who are interested in collective action support research that contributes to social mobilization for the enforcement of rights.<sup>10,11</sup>

### **Research's contribution to the universal right to health and effective access to health care**

To foster meaningful progress toward universal health coverage, researchers should classify countries with regard to how well they provide access to health care services. Comparative studies can then be undertaken to see ways in which successful systems differ from those that do not provide access. Such comparisons might involve conceptual and technical approaches, financing mechanisms, health outcomes, models of care, integration of networks, the coordinating role of primary care, contextual factors, labor relations, etc.

In order to be useful, these investigations must speak to two audiences.<sup>10,27</sup> The first includes civil society organizations such as political parties, unions, social and community associations, and patient self-help groups. These groups need to understand and analyze the various types of health systems and their attainment of health care coverage. This information will allow them to mobilize and make concrete demands concerning the implementation of the right to health. The second audience is policy makers; they need tools in order to analyze aspects of coverage, in order to make decisions aimed in that direction.

The way that information produced by research is incorporated into policies may influence public decisions and social mobilization. Research needs to clarify how different actors involved in the right to universal health both access and use the information that is provided to them. Questions of access, understanding, and use can be examined through qualitative research exercises. One can learn, for example, if research has been properly understood and ap-

plied, as well as the ethical and political contexts which allow for the use of results of research to guide public policy.<sup>28,29,30</sup>

A new approach in health systems research and health policy is required. We need research that is independent, adopts a (highly) critical approach, recognizes the expressed needs of the population, promotes direct contact between policy makers and communities, and incorporates a communication strategy that disseminates findings and recommendations in a way that connects the research to both the average citizen and the policy maker. This type of research would accept political and ethical engagement to help build just and equitable societies.

### **Conclusions**

Without any doubt, some health systems and health policies have already made major progress in the realization of the universal right to health.

Critical and independent research can help identify areas in which health policies fail to guarantee the right to health. Such evidence can encourage public debate and foster social mobilization to demand that the State live up to its responsibility for the effective universal guarantee of the right to health.

Research itself cannot achieve universal coverage, but it should provide critical information to the various stakeholders. These, in turn, can incorporate research findings into their mobilization and advocacy work to pressure governments to move toward universalization of rights. This requires health system researchers to consider and study how social actors can access and make use of their results. Perhaps the key factor for this translation to occur would be the involvement of social actors in the research process, from its design through to the development of conclusions and recommendations. The Latin American experience with action-research provides valuable guidance.

Research into the realities of health coverage is necessary. Without it political mobilization becomes rudderless. However, research disconnected from social dynamics ends up gathering dust in the archives.

Health researchers need to develop knowledge management in health that gathers researchers, poli-

cy makers, and communities. This should contribute to the social appropriation of knowledge and facilitate the use of research results for the benefit of the whole population – in this case, towards universal realization of the right to health.

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## References

1. Red Colombiana de Investigación en Políticas y Sistemas de Salud. *La gestión del conocimiento para la salud pública*. Medellín: PLANEA; 2009.
2. UN Committee on Economic, Social and Cultural Rights. *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*. Geneva: United Nations; 2000.
3. Akin J, Birdsall N, DeFerranti DM. World Bank. *Financing health services in developing countries: An agenda for reform*. Washington, DC: The World Bank; 1987.
4. De Groote T, De Paepe P, Unger JP. Colombia: In vivo test of Health Sector privatization in the developing world. *International Journal of Health Services*. 2005;35(1):125–141.
5. Homedes N, Ugalde A. Las reformas de salud neoliberales en América Latina: Una visión crítica a través de dos estudios de caso. *Revista Panamericana de Salud Pública*. 2005;17(3):210–220.
6. Hernández M, Torres-Tovar M. Colombia's new health reform: Keeping the financial sector healthy. *Social Medicine*. 2010;5(4):177–181.
7. De Vos P, De Ceukelaire W, Van der Stuyft P. Colombia and Cuba, contrasting models in Latin America's health sector reform. *Tropical Medicine and International Health*. 2006;11(10):1604–1612.
8. Torres-Tovar, M. Modelo de salud de Colombia: Exportable en función de los intereses del mercado. *Revista Saúde em Debate*. 2008;32(78/79/80):207–219.
9. Torres-Tovar, M. Los retos por desarrollar una salud pública en contraposición a una salud privada. *Revista Cubana de Salud Pública*. 2007;33(4).
10. De Ceukelaire W, De Vos P, Criel B. Political will for better health, a bottom-up process. *Tropical Medicine and International Health*. 2011;16(9):1185–1189.
11. Sanders D, Labonte R, Baum F, Chopra M. Making research matter: A civil society perspective on health research. *Bulletin of the World Health Organization*. 2004;82(10):757–763.
12. De la Cuesta, C. Investigación en salud: Reflexiones sobre el trabajo de Testa y Navarro. *Revista Facultad Nacional de Salud Pública*. 1996;13(2):51–62.
13. Wahlbeck K, Adams C. Beyond conflict of interest. Sponsored drug trials show more-favourable outcomes. *British Medical Journal*. 1999;318(7181):465.
14. Tungaraza T, Poole R. Influence of drug company authorship and sponsorship on drug trial outcomes. *British Journal of Psychiatry*. 2007;191:82–83.
15. Unger JP, De Paepe P, Van Dessel P, Stolkner A. The production of critical theories in Health Systems Research and Education. An epistemological approach to emancipating public research and education from private interests. *Health, Culture and Society* 2011;1(1):12–28.
16. Navarro V. Why some countries have national health insurance, others have national health services, and the U.S. has neither. *Social Science and Medicine*. 1989;28(9):887–898.
17. Paim J, Travassos C, Almeida C, Bahia L, Macinko J. The Brazilian health system: History, advances, and challenges. *The Lancet*. 2011; 377(9779):1778–97.
18. Rowland D, Pollock A, Vickers N. The British Labour government's reform of the National Health Service. *Journal of Public Health Policy*. 2001;22(4):403–414.
19. Fals O. *El problema de cómo investigar la realidad para transformarla: Por la praxis*. 7th ed. Bogotá: Ed. Tercer Mundo; 1989.
20. Castro R. *La vida en la adversidad. El significado de la salud y la reproducción en la pobreza*. Cuernavaca: Universidad Nacional Autónoma de México/Centro Regional de Investigaciones Multidisciplinarias; 2000.
21. Laurell C, Noriega M, Martínez S, Villegas, J. Participatory research on workers health. *Social Science and Medicine*. 1992;34(6):603–613.
22. Mercado FJ. *Entre el infierno y la gloria. La experiencia de la enfermedad en un barrio urbano*. Guadalajara: Universidad de Guadalajara; 1996.
23. Orozco MR. *Situación de la salud en el Petén. Diagnóstico participativo*. Guatemala: Consejo Departamental de Salud del Petén; 2000.
24. Breilh J, Granda E. Epidemiología y Contrahegemonía. *Social Science and Medicine*. 1989;28(11):1121–1127.
25. Bourdieu P. *Esquisse d'une théorie de la pratique*. Paris: Seuil; 2000.
26. Kuruvilla S, Mays N, Pleasant A, Walt G. Describing the impact of health research: A Research Impact Framework. *BMC Health Services Research*. 2006;6:134.

27. Hanney S, González-Block M. Yes, research can inform health policy; but can we bridge the 'Do-Knowing It's Been Done' gap? *Health Research Policy and Systems*. 2011;9:23.
28. Lavis JN, Davies HTO, Oxman A, Denis JL, Golden-Biddle K, Ferlie E. Towards systematic reviews that inform healthcare management and policymaking. *Journal of Health Services Research & Policy*. 2005;10(Suppl):35-48.
29. Garner P, Kale R, Dickson R, Dans T, Salinas R. Getting research findings into practice: Implementing research findings in developing countries. *British Medical Journal*. 1998;317(7157):531-5.
30. Bero LA, Grilli R, Grimshaw JM, Harvey E, Oxman AD, Thomson MA. Getting research findings into practice: Closing the gap between research and practice: An overview of systematic reviews of interventions to promote the implementation of research findings. *British Medical Journal*. 1998;317(7156):465-8.

