



REPORT BY THE SPANISH BIOETHICS COMMITTEE ON UNIVERSAL ACCESS TO THE HEALTH SYSTEM 2024



Comité de Bioética de España
Instituto de Salud Carlos III
Ministerio de Ciencia, Innovación y Universidades
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28029 MADRID (ESPAÑA)

Publicación incluida en el programa editorial del Ministerio de Ciencia, Innovación y Universidades.
Catálogo general de publicaciones oficiales:

<https://cpage.mpr.gob.es/>

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Report by the Spanish Bioethics Committee on
universal access to the health system
Ministerio de Ciencia, Innovación y Universidades
Instituto de Salud Carlos III
2025
Lengua/s: Inglés
NiPO: 156250135
Gratuita / Folleto / En línea / pdf

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This report has been prepared in response to the request of 17 June 2024 from the State Secretary for Health of the Ministry of Health for information from the Spanish Bioethics Committee on the ethical aspects that must be taken into account in relation to universal coverage and universal access to the health system.

After having received the request, the Committee prepared the report and approved it at a plenary meeting on 25 July 2024, pursuant to Article 78.1.a) of Act 14/2007 of 3 July 2007, on Biomedical Research, which stipulates that the functions of the Committee include issuing reports, proposals and recommendations for central and regional public authorities on matters with significant bioethical implications.

1. Introduction

That one person is in good health and another is not is neither fair nor unfair, in itself; however, the way in which a society addresses these health differences can be said to be fair or unfair. Inequality in health is tied to differences in health, which are considered unfair, among different groups of persons, linked to their social characteristics. It can thus be concluded that access to healthcare services and safeguards should ultimately be guided by the principle of justice, which is an ethical, legal and political value that is central to the organization of society.

There can be no justice without a minimum level of equality, which is why the principle of justice enables determination of which differences in health conditions among the population result in unfair inequalities. The same principle, once these differences have been identified, also enables commitments to be made to put mechanisms into place to ensure non-discrimination and equity.

The aim of this report is to offer reflection on the ethical aspects of universal access to the health system and particularly on the ethical grounds for universal access. Given that health is an essential value or resource, and healthcare and welfare services are vital and cross-cutting in terms of guaranteeing proper care of individual and collective health and the enjoyment of fundamental rights, it seems ethically justified to provide the entire population with access to such services and to state that justice constitutes the ethical grounds for such universal access.

This report will focus on the ethical dimension of universal and equitable access to the health system. Therefore, it will not examine the inequalities that continue to affect certain population groups after obtaining access to the National Health System, such as those relating to access to specialized services, the range of services offered, or diagnostic and treatment bias.

The considerations set forth herein are not limited to the sphere of justice; other factors must also be taken into account when designing public policy on access to basic healthcare. Issues such as diagnosis of infectious and contagious diseases and vaccination against them fall within the scope of responsible public health policies. In pursuing the key aims of such policies, it would be inappropriate to separate the population into different groups with different levels of access to healthcare based on criteria unrelated to situations of vulnerability. Therefore, although they are not analysed in this report, such considerations should be mentioned.

2. Health

Health is a universal prerequisite for a good quality of life, and is prized by people and communities. Because of its value and because it represents a duty as a matter of justice, health must be recognized and protected as a fundamental right, and one that is crucial for the enjoyment and protection of all other rights.

Health is not only a lack of illness nor can it be reduced to a solely biomedical dimension. Even the definition of health offered in the Constitution of the World Health Organization (WHO) is not entirely adequate (WHO, 1946): “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. More balanced and comprehensive concepts are needed, such as that provided in the WHO International Classification of Functioning, Disability and Health (ICF) (WHO, 2001), a biological, psychological and social framework that defines health, in terms of capabilities and functioning, as the result of a person’s interactions with their environment, thus enabling analysis of health needs in the context of a social, economic, political and legal system, considering health not only as an individual resource but also

a shared resource. Health is valuable because it enables people to pursue their life goals and interact with society; in other words, health can be considered a life opportunity (Daniels, 2007), or, preferably, as a basic human capability in the sense of central human capability (Nussbaum, 2011; Sen, 2009) and specifically as a person's ability to perform a set of human activities that enables them to develop the capabilities and basic functions necessary to enjoy health or be healthy (Venkatapuram, 2011; Ruger, 2018).

If health is not only necessary for survival but also for a full life, then this adds to its ethical dimension as a basic need (Walzer, 1983) and a human capability; i.e. it is an element without which one cannot have a dignified life or freely pursue one's life goals (Nussbaum, 2011; Sen, 2009).

Since health is a result of the interaction between individual and environmental factors (biological characteristics and needs, individual behaviour, and the physical and social environment), it should be understood as a combined capability, bringing together an individual's internal capabilities and appropriate external conditions. In terms of values, this entails leaving room for individual freedom, to enable each person to pursue their life plans in a basic context of equal opportunities or capabilities, which can become outcomes or functioning, through decisions or action.

Therefore, justice in the area of health must be concerned not only with individual aspects of health, but also with its determining factors from a social viewpoint. WHO defines the social determinants of health as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life" (WHO Commission on Social Determinants of Health, 2008). These forces and systems include economic policies and systems, development programmes, social norms and policies, and political systems. The social determinants of health are linked to collective health and inequalities in health, which, as previously mentioned, relate to the existence of worse health among less socially advantaged groups, such as people who live in or have lived in neighbourhoods of a lower socioeconomic level or people who are born in low-income countries.

3. Inequalities in health

Ensuring a minimum level of health capability for the entire population is therefore a duty as a matter of justice, calling for an end to unfair and inequitable inequalities in health—systematic differences in health between individuals or groups that are socially produced and result in some people being in worse positions to develop their capabilities (Whitehead, 1992). The differences are systematic because they do not appear at random; rather, they follow a continuous pattern across the population, affecting the most socioeconomically disadvantaged groups. They are socially produced because they are a result of social and not biological processes; in other words, health inequalities are not related to factors such as genetics, but to how society functions. These differences harm people in different ways, meaning that some individuals or groups have fewer guarantees and less protection of their basic capabilities and thus face worse conditions in which to pursue their life goals. For all of these reasons, inequalities are unfair, as they violate people's rights.

Examples of these unfair health inequalities include (Whitehead; Dahlgren, 2006; Borrell; Pasarín, 2024): (a) inequalities between geographical areas with different socioeconomic levels (Cofiño Fernández, 2013). Where a person lives (determining factors such as available services, environmental conditions, job opportunities and housing, all affected by economic factors) may have more of an influence on their health than their physiological conditions (biological inheritance or medical history). This is demonstrated by the fact that differences in life expectancy at birth between different neighbourhoods of cities in Spain are as

much as ten years; (b) inequalities suffered by women and non-binary persons, who generally present worse mental health and perceived health indicators than men (Krieger, 2020); and (c) the enormous differences in health indicators between people living in situations of vulnerability (e.g. people who have lost their housing) and the rest of the population.

4. Causes of inequalities in health

The model prepared by the Committee on Reducing Social Inequalities in Health in Spain (2012) (Borrell; Artazcoz, 2008; Borrell; Pasarín, 2024) was used to demonstrate the causes of inequalities in health and the factors, forces and systems that shape them. The model distinguishes between structural determinants and intermediate determinants of inequalities in health.

The structural determinants include:

1. The socioeconomic and political context, referring to factors that significantly affect social stratification, and how power and resources are distributed. The elements of this context are governance, political traditions, economic and social agents and forces (e.g. wars or large corporations), culture and values. The first two elements are the ones that determine policy on macroeconomic matters, the labour market and the welfare state, although such policy is increasingly dependent on bodies above the country level, such as the European Union. Other key policies are those on the environment and the climate emergency, which are now crucial to reduce inequalities in health and improve collective health and the health of our planet.

2. The axes of inequality, sometimes referred to as the “axes of power”. Social stratification is determined by different axes of inequality: social class, gender, age, ethnicity, race and place of origin or residence. These axes determine power hierarchies within society, which in turn affect opportunities for good health through exposure to “intermediate determinants”.

These axes of inequality share the following characteristics: (a) they are contextual and dynamic, as they change over time and from one geographical area to another; (b) they are social constructs and not biological in origin, meaning that they have nothing to do with our biology, but originate from social processes; (c) they are systems that involve power relations and domination: one group holds power over another, meaning that different groups have interests that not only differ from but also conflict with each other, as the privileges of those who wield power are directly related to a lack of privileges among those who do not; and (d) they exist both at a structural and macro level (society) and at a psychosocial or micro level (people and daily life).

It is important to recall that the axes of inequality do not operate independently from each other, but rather that they intersect. Thus, although women generally suffer worse health than men, if other factors such as social class or race are taken into account, other patterns become apparent, such as women from more privileged classes enjoying better health than working-class men.

Intermediate determinants include material resources, such as conditions of employment (precarious employment contracts or informal work) and work (physical risks, ergonomic risks, organization and psychosocial environment); unpaid work in the home or domestic work, and caregiving; income level and financial situation; availability, quality and fittings of housing, and neighbourhood or area of residence and the characteristics thereof. These resources, together with a persons’ position in the social structure, have an impact on health and on psychosocial processes such as self-esteem, emotional control, capacity to cope in stressful situations and behaviour or lifestyles that affect health (consumption of tobacco or alcohol, physical activity, etc.). Lastly, health services are another intermediate determinant.

Other conceptual models include among the social determinants of health factors such as those related to the environment or colonialism (Commission of the Pan American Health Organization on Equity and Health Inequalities in the Americas, 2019).

5. Inequalities in health and health services

Healthcare coverage and quality are two key indicators of social well-being. Adequate health services are vital to safeguarding the right to health, and therefore access to those services should be universal and equitable (Borrell and Pasarín, 2024). Barriers to health service access can take various forms, one of which is the lack of a health card or other document required to access such services. However, there are other barriers. The geographical barrier is a consequence of health services potentially not being equitably distributed across a country. The economic barrier originates from the payments that must be made to obtain certain services, such as dental services. Cultural and educational barriers include those linked to the difficulties that immigrants from low-income countries face when they attempt to use health services, the difficulties that people from socially disadvantaged groups experience when they are treated with attitudes that impair the quality of the service being provided, and difficulty accessing preventive healthcare or health education programmes. Lastly, digital barriers—because some members of the population do not have access to digital systems—are now significant, because telemedicine has become more common following the coronavirus disease (Covid-19) pandemic.

Examples of the impact of these barriers include immigrants being unable to access a healthcare agent who can help them interact with the healthcare system, older persons with limited resources who can access health services but cannot afford the costs of some treatments, or caregivers in the informal sector who have health problems as a result of the excessive burden of caring for an ill person who does not have access to sufficient support for their care.

These barriers to access are linked to the funding of health services and also to their coverage and organization. Funding for services is important because it determines their availability and accessibility. Moreover, funding mechanisms are related to the level of financial protection against the high cost of falling ill. Funding systems based on general taxation are predominantly more progressive (those with more income pay more). Under such a system, access to health services by income level or social class is usually more equitable, and if coverage is universal the whole population is protected financially in the event of illness. At the other extreme, privately financed systems are generally regressive, and access to health services and financial protection in the event of illness is often a privilege of people from more affluent classes.

Countries with health systems that are organized with a greater focus on primary care have better health indicators for their populations and smaller inequalities in health, in addition to incurring lower overall health service costs; therefore, they are more effective, efficient and equitable. The *World Health Report 2008: Primary health care now more than ever* (WHO, 2008) underlined the strengthening of primary care as a key strategy to effectively meet the needs of the entire population.

Most countries in the Organisation for Economic Co-operation and Development (OECD), except the United States, have almost universal health coverage, largely funded through direct taxation or social security contributions. Nonetheless, some comparative studies have found that use of specialized services is more frequent among higher-income persons, taking into account health level (OECD, 2019). These inequalities are less evident in the case of primary care and non-existent in hospitalization. In the case of Spain, lower

-income persons make more use of primary care and higher income persons use more specialized care. This pattern is related to the capacity of the higher-income population to use private services, and also their greater familiarity with how health services work (e.g. requesting appointments with specialists without first using primary care). Higher-income individuals also make greater use of dental services, which is linked to dental care not being publicly funded in most countries.

6. Justice as an ethical foundation for access to healthcare

The concept of justice is complex: it has different dimensions—ethical, legal and political—that relate to moral integrity and to guarantees of public order, and has become a more prominent issue since the publication of *A Theory of Justice* by John Rawls in 1971 (Rawls, 1971). In his defence of justice as equity (fairness), Rawls considers that citizens are able to engage in social cooperation because they have a sense of justice and a concept of goodness. This reflection must necessarily be completed with the requirement for subjective universality—an exchange of roles and equal consideration of all persons concerned—and the universal nature of justice, defined in discourse studies as a desire for correctness or justice in any ethical or legal discourse (Habermas, 1984a and 1984b; Apel, 1988; Alexy, 2021), that springs from a cordial or compassionate reason, with a capacity for indignation in the event of injustice or distress in the face of suffering (Cortina, 2010).

Rawls also holds that society must guarantee for all people the same set of basic liberties enabling equal opportunities, compatible with an unequal distribution of social goods that can only be made fair if efforts are made to improve the circumstances of the least favoured people and groups, in accordance with the difference principle. Lastly, the structural aspect of justice must be taken into account; justice does not depend solely or primarily on individuals who are just or on justice as an individual virtue, but rather on a fair organization of social institutions. From this viewpoint, certain inequalities in health are specifically a result of structural injustice, whereby some groups of people are deprived of the possibility of enjoying certain freedoms or capabilities owing to certain social processes originating from a combination of factors that cannot be attributed to specific individuals or policies (Young, 2011). Therefore, eradicating inequalities in health entails different actions, not only those specific to health, as access to a quality healthy system and universal health coverage are vital, but not enough on their own to end those inequalities and bring about equity in health (Fernández Ruiz-Gálvez, 2019).

The approach based on the social determinants of health (Lema Añón, 2020) specifically targets structural injustice, calling for changes not only in living conditions, but also in social structures that lead to inequalities, as well as a rebalancing of the inequitable distribution of power, money and resources. In this framework, in addition to establishing criteria to make equal opportunities fair and balance out differences, aspects must be included that enable human beings to flourish and freely pursue their life goals, making use of their capabilities, including the different dimensions of health.

In view of the above, the purpose of legal and political intervention to counteract inequalities in health should be to provide citizens with the means and conditions necessary to have a realistic chance of choosing what they consider to be most valuable and act accordingly. A relevant ethical and political concept is the aforementioned health capability, which is conceived as a combined capability: the internal capabilities of a person combined with appropriate external conditions, with freedom enough for each person to determine their good and pursue it in a context of equal opportunities, and for them to be able to continue to exercise and guarantee those capabilities over time (Wolff, 2012). Thus, health is one of the basic capabilities, connected

to other capabilities that enable a dignified human life to be guaranteed; and freedom and equality appear as fundamental and indispensable values and principles of justice in health, with two aims: to eradicate inequitable inequalities in health and to guarantee health capabilities.

One question remains. The reflection on justice and universal access to healthcare and the health system relates to the distributive dimension of justice, which is to say the correct allocation of benefits and burdens. This call for distributive justice is correct, but incomplete, as it is also vital to analyse the institutional conditions that are needed to enable the development and enjoyment of individual capabilities; these conditions are linked to justice as a form of recognition. Furthermore, this recognition must precede distribution, as it facilitates inclusion of all persons, improves the justification of the distribution and strengthens participation and representation, which are part of the political dimension of justice (Fraser, 2008); in other words, it offers greater guarantees of subjective universal coverage, without unjustified exclusions. Therefore, the core normative categories of justice as recognition are not identity, equitable distribution or equality, but dignity and respect, understood as prerequisites for fair intersubjective relationships and remedy of objectification or exploitation of people and their treatment as exchangeable goods or objects (Honneth, 2012).

Justice as recognition reflects above all the intersubjective dimension of recognition, comprising the need to be recognized by others to fulfil one's identity and recognize oneself, and within its three levels it refers to legal recognition and rights. Unlike the other two levels—love and solidarity or social esteem—legal recognition is more enforceable and is universal and categorical in nature: all human beings, merely by existing, regardless of their individual qualities, merit recognition of and respect for their rights. Therefore, any exclusion or stripping of rights is a form of contempt that must be considered unjust (Honneth, 1995).

7. Health as a right

The Spanish Constitution recognizes the right to protection of health and establishes the duty for public authorities to safeguard health in several ways: education, preventive measures, and care, all of which are stipulated to be constitutionally regulated and guaranteed. The interrelated nature of basic capabilities is also visible in the area of rights. Even though it is not granted the status of fundamental right, the right to health protection is closely interrelated with other fundamental rights, and particularly the right to life and to physical integrity, which are recognised in Article 15 of the Constitution, for all people, without exception, especially in the case of health coverage and access to the National Health System.¹

At the international level, health is already considered a right in the *Constitution of the World Health Organization* (WHO, 1946). This is particularly noteworthy for three reasons: it does not refer solely to the recognition of the right to health, but to the “enjoyment of the highest attainable standard of health”; it states that this is a fundamental right; and it emphasizes its universal nature, of all human beings, without any discrimination.

1. See Judgment of the Constitutional Court 139/2016, of 21 July, legal ground 10, and above all the dissenting opinion of Judge Fernando Valdés Dal-Ré, seconded by Judge Adela Asúa Batarrita, underscoring the instrumental link between the right to health protection and the fundamental rights to life and integrity (Section II.2), supported by constitutional case law: Jurisdictional Orders of the Constitutional Court 239/2012, of 12 December, legal ground 5; 114/2014, of 8 April, legal ground 8; and 54/2016, of 1 March, legal ground 5.

At the global level, this right also appears in the *Universal Declaration of Human Rights* (United Nations, 1948), Article 25.1 of which states that: “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services...”.

In terms of enforceability, Article 12.1 of the *International Covenant on Economic, Social and Cultural Rights* (United Nations, 1966) is more significant, as the most comprehensive expression of international human rights law: “The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”. The concept of health put forward in this document also links to the preceding article (Article 11.1) which recognizes the “right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions...”.

General Comment No. 14 of the Committee on Economic, Social and Cultural Rights (CESCR, 2000) is also crucial to determining the scope of the right to health of Article 12, and is perhaps the document that most specifically and clearly defines the scope of health in terms of justice. It opens with an emphatic statement: “Health is a fundamental human right indispensable for the exercise of other human rights” (paragraph 1) and then follows by specifying that the right to health “is closely related to and dependent upon the realization of other human rights... including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health” (paragraph 3), thereby confirming the link between the individual dimension and the contextual dimension and the social determinants of health. It later reaffirms this position, calling the right to health “an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels” (paragraph 11).

However, the *General Comment* qualifies the meaning of the right to health in one respect that is pertinent to this document, when it clarifies that it “is not to be understood as a right to be *healthy*. The right to health contains both freedoms and entitlements ... the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health” (paragraph 8). The *General Comment* also provides an extensive list of international and regional legal instruments on the matter.²

Other instruments include the *Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine*

2. “Additionally, the right to health is recognized, *inter alia*, in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, in articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979 and in article 24 of the Convention on the Rights of the Child of 1989. Several regional human rights instruments also recognize the right to health, such as the European Social Charter of 1961 as revised (art. 11), the African Charter on Human and Peoples’ Rights of 1981 (art. 16) and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (art. 10). Similarly, the right to health has been proclaimed by the Commission on Human Rights, as well as in the Vienna Declaration and Programme of Action of 1993 and other international instruments.” In the field of international human rights treaties, the Convention on the Rights of Persons with Disabilities (United Nations, 2006) would have to be added.

(Council of Europe, 1997a), Article 3 of which addresses equitable access to healthcare, stipulating that the Parties (in this case Spain), “taking into account health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality.” The *Explanatory Report* to the Convention (Council of Europe, 1997b) confirms that obligation and states that the “aim is to ensure equitable access to health care in accordance with the person’s medical needs” (paragraph 24). It then indicates that the term “equitable” means “first and foremost the absence of unjustified discrimination. Although not synonymous with absolute equality, equitable access implies effectively obtaining a satisfactory degree of care” (paragraph 25).

The *Charter of Fundamental Rights of the European Union* (European Union, 2016) also recognizes and safeguards a right to health protection: “Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union’s policies and activities” (Article 35). In addition to its link to the right to life (Article 2) and the right to the integrity of the person (Article 3), the right to health protection is related to and completed by “the entitlement to social security benefits and social services providing protection in cases such as maternity, illness, industrial accidents, dependency or old age...” (Article 34.1). Recognition of all these rights and respect for them place limits on national legislators when determining their scope and level of protection (Articles 52 and 53).

Lastly, including at the international level, are some of the references in the explanatory memorandum of the Bill on universal coverage of the National Health System: Resolution 67/81 of the General Assembly of the United Nations of 12 December 2012, on global health and foreign policy (United Nations, 2012); Resolution 70/1 of the General Assembly of the United Nations of 25 September 2015, adopting the 2030 Agenda for Sustainable Development and its 17 Sustainable Development Goals, and specifically Goals 3 and 10 (United Nations, 2015); and the European Pillar of Social Rights (Council of the European Union, 2017) and particularly its Principle 16.

In summary, one document worth mentioning is the WHO report *Advancing the right to health: the vital role of law*, which opens by emphasizing that the “right to health is a fundamental human right that is indispensable for human well-being, for well-functioning societies and economies, and for the ability to exercise all other human rights. Without a basic level of health, it may be difficult or impossible for people to work, to attend school and obtain an education, to enjoy recreation, to fully participate in society, and to enjoy other basic freedoms” (WHO, 2017). The report also states that legislation and strong legal frameworks are playing an increasingly important role in offering the security and justice of a State governed by the rule of law (Article 1.1 of the Spanish Constitution). The passing of the Bill on universal coverage of the National Health System would increase the effectiveness of the guarantee of health because it would be legally binding, as a national legislative instrument.

8. Universal access to health protection as a question of justice and as a right

The combination of the different dimensions of justice with the most basic concept of health capability, and the legal manifestation of health as a right, together enable two legal and political levels of ethical activity to be established: guaranteeing minimum levels of healthcare and social care, and providing wider support and assistance for health and well-being (Seoane, 2024).

Level 1. *Core or basic obligations.* A lack of coverage or of access to the system not only harms the health and physical integrity of a person through illness, suffering or pain, but also through humiliation or exploitation, violating their dignity, which is at the heart of their rights. It is at this level, of justice as recognition, that categorical fundamental values and legally enforceable constitutional rights are protected, with a system of protection that may be set out in legislation or in regulations.

Each State must guarantee a minimum level of health protection with: (a) availability: coverage of the entire population; (b) accessibility: non-discrimination and physical, economic and information accessibility; (c) acceptability: respect for professional standards for medical ethics and for cultural differences; and (d) quality: scientifically and medically appropriate; vocational training, technical resources, etc. (paragraph 12 of CDESCR, 2000).

Level 2. *Progressively realized aims.* This level refers to distributive justice and takes the form of rights set out in legislation or regulations, depending on the socioeconomic context and the decisions made on distribution as part of the political process and civic deliberation.

Although it may not be possible to resolve all health inequalities, it is important to differentiate between these two levels to ensure a threshold or basic minimum level below which a lack of coverage or of healthcare would violate the dignity of the people concerned, as well as several of their rights. The aim is not for all people to enjoy the same health, but rather for people to enjoy a sufficient level of health to lead a good life (Fourie; Rid (ed.), 2017; Powers and Faden, 2006), including at the primary level the guarantee of universal access to the National Health System that constitutes the purpose of the Bill on universal coverage of the National Health System and similar legislative initiatives, combined with a second level relating to other resources and possibilities that enable health to be developed, in a wide and overarching sense, as a space for improving people's lives.

Therefore, the equitable universal access of level 1 (core or basic obligations) should be interpreted in two ways. Firstly, subjectively, referring to any person, without distinction, as the beneficiary of the duty to provide health protection and holder of the right to health protection. Secondly, in a territorial sense, so that legislative and health policy differences among competent subnational authorities and bodies, such as those of Spain's Autonomous Communities or of its municipalities, do not lead to unequal treatment that hinders effective guarantees throughout Spain of the adequate minimum access, healthcare coverage and the shared range of services of the National Health System.

Lastly, three significant factors must be taken into account when determining the scope of the two levels in terms of justice (German Ethics Council, 2011): (1) the irreversibility of certain health decisions prevents subsequent redistribution of non-fungible or non-exchangeable goods (life, integrity, health), which cannot be treated as objects or mere resources, as such treatment would not guarantee respect for human dignity; (2) although a shortage or lack of resources may prevent all needs being met simultaneously, the rights-based approach emphasizes equal opportunities; and (3) policies that favour efficiency (economistic profit maximization), that have majority-based criteria (utilitarianism), that focus solely on outcomes (consequentialism) or that overlook the social and well-being aspects of healthcare (libertarianism) may violate individual rights.

Some of these perspectives might be acceptable at level 2, but only if the threshold set at level 1 for basic or core obligations, undoubtedly including universal and equitable access to the National Health System, is not exceeded.

9. Regulation of the right to healthcare and access to the National Health System

The current organizational model of Spain's National Health System originates from the General Healthcare Act (Act 14/1986 of 25 April) passed in 1986, which implements Article 43 of the Spanish Constitution of 1978. It is a rights- and justice-based model, which substituted the previous system, a contributory one, in place since the passing of the Act of 14 December 1942 establishing compulsory health insurance, and prior charity-based models.

The system prioritized the need to extend the guarantee of healthcare beyond workers and their families, establishing a right to healthcare for all people living in Spain. The laws and regulations subsequently enacted—essentially the Act on National Health System cohesion and quality (Act 16/2003 of 28 May, hereinafter the NHSCQ Act) and the General Public Health Act (Act 33/2011 of 4 October, hereinafter the GPH Act)—effectively expanded these rights to the migrant population, who thus held the same health card as the rest of the population, irrespective of their legal status.

However, the situation changed considerably in 2012, following enactment of Royal Decree-Law 16/2012 of 20 April, on urgent measures to guarantee the sustainability of the National Health System and improve the quality and security of its benefits (hereinafter RDL 16/2012), which established a strict link between recognition of the right to healthcare and Social Security contributions, limiting foreigners' access to this right, in order to improve the solvency and viability of the system. The change was reflected in an amendment to Article 3 of the NHSCQ Act and the addition of two new articles: 3 bis and 3 ter.

In 2018, Royal Decree-Law 7/2018 of 27 July, on universal access to the National Health System (hereinafter RDL 7/2018) ended that situation, with a preamble that proclaimed a return to universal coverage with the explicit aim of guaranteeing universal care, which is to say the right to protection of health and to healthcare, under the same conditions, for all persons in Spain, through reinstatement of the right to health protection and healthcare for all people residing in Spain, regardless of their nationality. To achieve this, Articles 3, 3 bis and 3 ter of the NHSCQ Act were amended.

The return to universal healthcare access provided for by RDL 7/2018 has not occurred in practice, owing to a combination of a territorial factor and a personal factor: the differences in legal treatment among Spain's Autonomous Communities and between people who are Spanish citizens or residents and people with irregular status, in terms of recognition of the right to healthcare.

In the period from 2012 to 2018, many regional regulations were enacted, whose primary purpose was often to prevent application of the restrictive policies of RDL 16/2012 with respect to people with irregular status or without residence permits. One unintended consequence has been a fragmented regulatory framework, with substantial differences among Autonomous Communities and harmful repercussions for the guarantee of universal coverage, giving rise to different levels of recognition of the right to care between people who have citizenship or legal residency and those whose status is irregular. Considerable barriers have also been established for those living in particularly or extremely vulnerable circumstances, who are the intended beneficiaries of the reform set out in RDL 7/2018. In short, the situation represents multiple problems with respect to equity and legal certainty and introduces an element into the National Health System that is redolent of charity and is not becoming of it nor of the concept of health as a right (Yo Sí Sanidad Universal, 2022).

It is in this context that the Bill on universal coverage of the National Health System of 24 May 2024 appears,³ which is the subject and purpose of this report. That Bill was recently followed by the Bill to amend several rules to improve the equity and cohesion of the National Health System of 28 June 2024.⁴ These two bills were preceded by another failed bill that had a similar aim: the Bill to amend several rules to improve the equity, universal coverage and cohesion of the National Health System of 24 June 2022.⁵

10. An ethical reading of the Bill on universal coverage of the National Health System

From an ethical standpoint, what should be asked of the Bill on universal coverage of the National Health System? In addition to fulfilling the requirements of the legislative process (see paragraph III of the explanatory memorandum), it should pursue and realize an ethically valuable aim, which in this case is guaranteeing the universal health access and coverage of the National Health System, and align and adapt resources to achieve that aim. Paragraph I of the explanatory memorandum to the Bill describes this in more detail (unofficial translation): This law sets out measures to consolidate the principles of equity and universality in the National Health System. To achieve this, it expands the healthcare coverage of the National Health System to new population groups, reinstates the unified shared range of services of the System, clarifies and specifies its services, and prevents new co-payment measures being introduced. The aim is to facilitate development of more effective and efficient public health policies and comprehensively address the population's health protection needs, thus ensuring appropriate responses to current and future demographic, environmental, social, technological and economic challenges.

In other words, this Bill—or rather the Act, once passed—should confirm that access to healthcare and health protection is a question of justice and should ensure that the ethical aspect of justice is put into practice through real and effective justice for all, under fundamental conditions of freedom and equality, reaffirming the three dimensions of correctness of legal norms: legality, legitimacy and effectiveness.

This viewpoint strengthens the aforementioned link between health capability and the importance of the law in protecting it, which should be fully taken into account in the Bill. Being able to live within the limits of the law, and to respect it and comply with it, as well as knowing and understanding duties and rights within an accessible and intelligible legal system are basic conditions and capabilities for a good and satisfying life (Wolff; de-Shalit, 2007). Therefore, if legislation is non-existent or unclear, is ineffective in pursuing its aims, or goes against the basic values that should form its basis, extreme situations may arise in which the persons concerned—healthcare professionals and users—find themselves forced to act outside the law to

3. See Proyecto de Ley 121/000021. Proyecto de Ley de universalidad del Sistema Nacional de Salud. *Boletín Oficial de las Cortes Generales*. Congreso de los Diputados, XV Legislatura, Serie A: Proyectos de Ley, núm. 21-1, 24 de mayo de 2024, pp. 1-16. https://www.congreso.es/public_oficiales/L15/CONG/BOCG/A/BOCG-15-A-21-1.PDF.

4. See Proyecto de Ley 121/000029. Proyecto de Ley por la que se modifican diversas normas para consolidar la equidad y cohesión del Sistema Nacional de Salud de universalidad del Sistema Nacional de Salud. *Boletín Oficial de las Cortes Generales*. Congreso de los Diputados, XV Legislatura, Serie A: Proyectos de Ley, núm. 29-1, 28 de junio de 2024, pp. 1-18. https://www.congreso.es/public_oficiales/L15/CONG/BOCG/A/BOCG-15-A-29-1.PDF.

5. See Proyecto de Ley 121/000110. Proyecto de Ley por el que se modifican diversas normas para consolidar la equidad, universalidad y cohesión del Sistema Nacional de Salud. *Boletín Oficial de las Cortes Generales*. Congreso de los Diputados, XIV Legislatura, Serie A: Proyectos de Ley, núm. 110-1, 24 de junio de 2022, pp. 1-28. https://www.congreso.es/public_oficiales/L14/CONG/BOCG/A/BOCG-14-A-110-1.PDF.

protect and prevent violation of basic values and capabilities such as health.

This entails taking on moral responsibility and committing to the values of health and justice. It calls for involvement in civic deliberation processes, during which consideration must be given to possible emotional manipulation in public discourse or political exploitation of emotions.

A guarantee of universal access to the National Health System, which is the aim of the Bill, should be viewed as a basic and core obligation (level 1) and thus extended and applied to all persons. Equitable universal access should be interpreted both subjectively and individually (any person, without discrimination, whether it be social, economic, demographic or based on nationality, residence, legal status or any other factor) and territorially, to ensure a minimum level of coverage and access on an equal footing throughout Spain. In this regard, it is important for this legislative reform to guarantee access to healthcare for all residents of Spain, irrespective of which Autonomous Community or municipality they live in and of their social conditions. To do otherwise would be to put efficiency before justice, put the majority first, marginalize minorities, violate individual rights and overlook the social and benefits dimensions of rights, and to ignore the importance of universality or universalizability as a criterion of moral correctness (Kant, 2004).

The ethical and political responsibility to end inequalities in health and guarantee universal access to the health and social security systems and to healthcare lies with public authorities, as a reflection of their commitment to the rule of law, democracy, social assistance and the values of freedom, equality and justice, as well as the protection of rights. That responsibility—in this case for the executive and legislative branches—does not end with putting a bill to parliament, or when it is passed or implemented; public authorities also have a duty to maintain and improve the health and social security system, to enable comprehensive health protection for the entire population, continuously upholding ethical values and fulfilling the aforementioned goals.

However, ethical responsibility is not solely the domain of public authorities, and concerns all citizens, who are responsible for contributing to ending inequalities, guaranteeing freedom, equality and justice, and defending rights. Furthermore, citizens, both as users and as professionals, are responsible for contributing to the upkeep and proper use of the health and social security systems, to facilitate the continued application of the ethical values at stake and the achievement the aforementioned goals.

11. Conclusions

- Health inequalities are a question of justice that reflects systemic problems and social, political and economic determinants.

- Justice in health is affected by the social determinants of health, which are the circumstances in which people are born, grow up, work, live and age, including a wide range of forces and systems that have an impact on daily life.

- The socioeconomic and political context and the different axes of inequality—social class, gender, age, ethnicity or race and place of origin or residence—shape social stratification and determine power structures and distribution, thus affecting opportunities for good health.

- Ensuring a minimum capability for health calls for an end to unjust or inequitable health inequalities, which is to say the health differences among individuals or population groups that are systematic, of social origin and lead to differences in the pursuit of life goals.

- The ethical, legal and political response to health inequalities requires an integrative and overarching approach—one that is suited to the multidimensional nature of health—to the measures needed to safeguard it, and the needs and characteristics of the people who use social and health services to care for their health.

- The right to healthcare and National Health System access forms part of the model set out by the General Healthcare Act of 1986, implementing Article 43 of the Spanish Constitution of 1978. It is a rights model based on justice, which substituted the previous contributory system, which in turn was preceded by a charity-based system.

- Universal health coverage and universal National Health System access have not been guaranteed either in the initial model of 1986 or through the subsequent laws on protection that have been passed: the NHSCQ Act of 2003 and the GPH Act of 2011. The reform in 2012 magnified this deficiency and moved further away from universal coverage by adding exceptions to the contributory model. Nor was the 2018 reform able to guarantee universal coverage, and it was hampered by the plethora of different regulations in the Autonomous Communities, thus adding location-based inequalities to the existing subjective inequalities. In short, the situation is one of inequalities in health, with problems concerning equity and legal certainty, all of which is incompatible with a genuine rights model.

- Health is not only necessary for survival but also to live a dignified and satisfying life. It should be understood as a basic human capability, originating from interaction between an individual's internal factors and capabilities and external contextual factors and conditions; in other words, it is a combined capability that in ethical terms calls for freedom of choice and freedom of agency, and a context of equal opportunities.

- Apart from health, justice is the main value to consider when analysing universal health system access, in ethical terms and in legal and political terms.

- Nonetheless, justice is not the only resource or value to be considered, as it exists alongside others, which also influence it, such as dignity, freedom, equality, personal integrity and security, which are vital components of the catalogue of human rights and fundamental rights and freedoms.

- Justice calls for a combination of identical fundamental freedoms to enable each individual to exercise health capabilities, and to end structural injustices, as it does not depend solely on individuals' upright or fair behaviour, but also on fair organization of social institutions, which on occasion deprive groups of individuals of the ability to exercise their capabilities, freedoms and rights.

- In view of structural injustice and the social determinants of health, ending inequalities in health calls for essential measures in the areas of health and social security, such as universal access to quality health and social security systems; however, these measures will not be enough to bring about justice or equity in health if they are not accompanied by actions to change the social structure and the inequitable distribution of power and resources.

- Ethical, legal and political action on health should pursue two aims: eradicating inequitable inequalities in health and guaranteeing health capabilities.

- Universal healthcare coverage and universal health and social security system access require the consideration of justice from two viewpoints. Firstly, justice as recognition, focusing on respect for the dignity of all people and prevention of their exploitation or objectification, with inclusion of all, increasing participation and representation and improving distribution. Secondly, distributive justice, which proportionally distributes goods and burdens, but only once universal inclusion and participation has been achieved through recognition.

- A basic level of health is vital for education, work, leisure, full participation in society and enjoyment of other fundamental freedoms. Accordingly, health protection is considered a right at the national and international levels, and one that is closely tied to other rights, particularly the fundamental rights to life and integrity.

- Guarantees of individual and collective health require various measures, including a health protection system that offers people equal opportunities to enjoy the highest possible level of health; in other words, a system with universal access.

- One decisive tool to guarantee individual and collective health is the model of a State governed by the rule of law, within which a robust legal framework must be developed and strengthened, to offer justice, legal certainty and effectiveness, by enacting appropriate law. In the Spanish State, which is social and democratic and governed by the rule of law, this would apply to the Bill on universal coverage of the National Health System, which is an apt legal instrument with which to achieve universal health coverage and universal access to the health system.

- Given the consideration of health as a right and the two levels of justice previously described—recognition and distribution—any legal proposition that aims to end health inequalities or reduce them must take into account the possibility of distinguishing between two levels of action, as the goal is not for all people to have the same level of health, but for all people to enjoy a sufficient level of health to lead a good life. Level 1, justice as recognition, governs the basic or core obligations and categorically guarantees protection of basic values such as dignity, health and integrity--and life--by recognizing constitutional, legally enforceable rights, and ensuring their legislative or regulatory implementation. Level 2, distributive justice, refers to aims to be progressively pursued and to duties and rights set out in legislation or regulations, depending on the socioeconomic context and civic and political decisions on distribution.

- Guarantees of universal access to the National Health System, which are the aim of the Bill on universal coverage of the National Health System, belong to level 1. Therefore, they should be recognized and applied to all people. Equitable universal access must be interpreted both subjectively and individually (any person, without discrimination, whether it be social, economic, demographic or based on nationality, residence, legal status or any other factor) and territorially, to ensure a minimum level of coverage and access on an equal footing throughout Spain. Failure to do so will put efficiency before justice, put the majority first, marginalize minorities, violate individual rights and overlook the social and benefits dimensions of rights and to ignore the importance of universality or universalizability as a criterion of moral correctness.

- The ethical and political responsibility to end inequalities in health and guarantee universal access to the health and social security systems and to healthcare lies with public authorities, as a reflection of their commitment to the rule of law, democracy, social assistance and the values of freedom, equality and justice, as well as the protection of rights. Public authorities also have a duty to maintain and improve the health and social security system, to enable comprehensive health protection, continuously upholding ethical values and fulfilling the aforementioned goals.

- Citizens have a duty to contribute to ending inequalities, to guaranteeing freedom, equality and justice, and to defending rights through public debate. Furthermore, citizens, both as users and as professionals, are responsible for contributing to the upkeep and proper use of the health and social security systems, to facilitate application of the ethical values at stake and achieve the aforementioned goals.

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