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INTERSECTIONS OF HEALTH RIGHTS AND ECONOMIC CRIMES

Economic crimes have a detrimental effect on the integrity of public financial systems, compromising the accessibility and quality of healthcare services by diverting resources away from the healthcare system. This creates a ripple effect that exacerbates health inequalities, particularly for vulnerable populations who rely heavily on public health services. This paper explores the relationship between health rights, economic crime, government policies and budget cuts. Access to healthcare is directly linked to economic stability, sound fiscal management. Economic crimes disproportionately affect the most vulnerable members of society, including low-income households, the elderly, prisoners, young children, and the chronically ill causing further marginalisation. Healthcare can function as a social and penal tool, and has specific implication in marginalised environments. This emphasises the necessity of ensuring the integrity of the judicial system when investigating economic crimes and the need for interdisciplinary collaboration between health and legal professionals to promote health equity from a criminal justice perspective.

Keywords: *right to health, economic crime, access to healthcare, vulnerable population in healthcare, economic justice, marginalised groups.*

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1. Introduction

Significant losses in public revenues are caused by economic crimes such as tax evasion, corruption and money laundering. This has a direct impact on the financing of public services, particularly healthcare systems. Underfunded healthcare systems experience staff shortages, outdated infrastructure and long waiting times, all of which disproportionately affect poor and vulnerable populations. Persons in vulnerable social class, race, lower socioeconomic status, and other minority groups have the highest burden of chronic diseases (Havranek et al., 2015). In this perspective this article presents an interpretation of how healthcare systems, especially when underfunded or inadequately accessible, can operate as implicit mechanisms of punishment especially towards marginalised groups.

Marginalisation may be illustrated as a process through which certain population groups experience multiple social determinants concurrently. Creating margins and vulnerabilities is limiting access of marginalised, vulnerable populations to health promoting resources, while increasing their risk for poor health (Baah et al, 2019). These individuals cluster in residential areas notable for limited employment and educational opportunities as well as affordable healthcare services (Havranek et al., 2015).

I propose reframing the concept of "denial of healthcare" not as a passive failure but as an active tool of social control. Drawing on theoretical foundations such as Wacquant's theory of punitive neoliberalism (2009) and Farmer's concept of "structural violence" (2004), the study extends their insights to demonstrate how non-criminal state systems can adopt punitive functions.

From criminological and institutional perspectives there is an interdependence between economic crime and health rights. The paper addresses the unexplored intersection of criminal justice, public health policy, and economic governance. By linking fiscal decisions to outcomes in both healthcare and incarceration, it show how systemic neglect operates as an informal mechanism of population control. Illicit financial practices can lead to structural underfunding and the erosion of public services by influencing decisions to cut budgets, resulting in increased health inequalities. In societies where economic governance is weak or distorted by criminality, healthcare becomes inaccessible to those who depend on state-provided systems the most, including low-income populations, prisoners, ethnic minorities and other vulnerable groups. The COVID-19 pandemic provides a historical and empirical frame that underscores these arguments. Although widely studies, the long-term consequences of reduces access to healthcare during lockdowns – especially for prisoners, the elderly, the undocumented persons – have rarely been inter-

preted through a lens of institutionalised exclusion. The present study proposes an interdisciplinary approach, integrating the fields of law, health and criminology, as a means of addressing systemic exclusion. The paper emphasises how economic distribution influences, and how economic criminality undermines, the operational integrity of public health systems and society as a whole. It highlights the need for institutional accountability and targeted policy interventions in custodial and non-custodial contexts, with the aim of expanding international debates around human rights obligations.

2. Marginalisation and access to health

Social inequality results in intentional rejection with demotion to a powerless position in society, which severely restricts survivability. This act of rejection is perpetuated through ideologies such as racism, classism, colonialism, and constrictive gender role norms perpetuated through mechanisms such as implicit bias, bullying, stigmatisation, scapegoating, residential segregation, mass incarceration, inequity in pay rates, disparities in unemployment rates, and lack of access to affordable healthcare services. Thus, resulting in the restriction of participation in the use of social and health care services (Baah et al., 2019). The cumulative outcome of these conditions is increased economic burden that results in increased vulnerability among the marginalised group. Marginalisation is a particular problem in cases where a lifestyle change is required, such as in the case of serious illness. Socioeconomic deprivation and the unequal distribution of healthcare services, which were evident during the course of the pandemic, have been demonstrated to result in the marginalisation of individuals suffering from chronic diseases. This, in turn, has been shown to lead to a systemic deterioration of their condition (Baah et al., 2019). As Baah et al. (2019) demonstrate, the disproportionate distribution of resources at this social level leads to differential life conditions and, consequently, differential health outcomes among population groups. This has specific implications for penal environments too. Populations such as the homeless, black men, immigrants, refugees, the unemployed, abused women, and the chronically ill are marginalised; hence, they experience limited access to health care services, education and other basic needs (Havranek et al., 2015). Human interactions within the social and built environment set the individual on a path towards systemic physiologic and social deterioration that led to poor health outcomes. This process of deterioration results from a "pattern of disparate risk of social categorisation that makes marginalisation a major health concern" (Hall, Carlson, 2016). It is easy to see that, through this type of socio-economic categorisation, healthcare becomes the primary tool for managing these groups, depending on the type of state in question – whether neoliberal, Keynesian, modern, or based on the rule of law

(Wacquant, 2001: 401). This issue has become increasingly important amid global public health crises and growing economic inequalities.

Marginalised groups, such as those on low incomes, ethnic minorities and rural populations, thus often face multiple barriers when trying to access healthcare. These include financial difficulties, geographical distance and institutional discrimination. In underfunded systems, these groups frequently lack timely or adequate care, exacerbating existing health disparities.

The underfunding of healthcare systems can be a form of structural violence, systematically preventing the most vulnerable people from accessing healthcare. This can lead to higher rates of illness and death among marginalised groups, reducing their presence and influence in society. Also, if a country undergoes economic devolution, its gross national product and life expectancy will both decline (Farmer, 2004: 313). Therefore, economic crimes also play a crucial role in access to healthcare for the vulnerable. Denying access to health services can thus be viewed as a tool of social control.

3. Policy making and healthcare

On the other hand, action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities too. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs. (Marmot et al., 2010).

Underfunding of health systems and economic crime have a negative impact on the economy as a whole. Poor population health reduces labor productivity, increases public spending on social services and stifles economic growth. Rising social inequality also contributes to social tension and instability. Clearly, it is important to take account of the probability that richer countries will spend more, which could produce an artefactual association between good health as a result of relative wealth and overall higher social welfare spending. Higher gross domestic product (GDP) is indeed associated with lower mortality (Stuckler et al., 2010). Both addressing health inequities and combating economic crime are political and ethical imperatives. The study also adopts a historical perspective to highlight the evolving roles of healthcare and the interplay between state power, the economy, and social control as determinants of health. Recessions have had profound economic consequences for many countries. The timing and extent of budget deficit reductions are a key issue in general elections worldwide. When it comes to making cuts in public expenditure as a percentage of GDP, economists have widely divergent views on whether these cuts aid or hinder economic recovery. However, they pay scant attention to the potential effects of reductions in health expenditure on population health

(Stuckler et al., 2010). This includes ensuring adequate funding, transparency, and accountability within health systems[1]. It is important to note at this point that healthcare is a multifaceted tool for promoting well-being and social control. In its response to the global fight against certain epidemics, medicine adopted bacteriology and virology in an attempt to eradicate disease by eliminating the perceived or targeted carriers (Weindling, 2011: 16). In this view the quality of a nation's healthcare system – which mainly depends on economic and budget distribution decisions – is also a key indicator of its commitment to human dignity, social justice and sustainable economic development.

4. Access to health in penal institutions

Incarcerated individuals as members of a state-dependent subpopulation, often reflect the broader successes and failures of public health infrastructure. Cases such as Gülay Çetin v. Turkey (2013) and Kalashnikov v. Russia (2002), as heard by the European Court of Human Rights, also highlight that when financial mismanagement, corruption and economic crimes divert resources away from public systems, prison healthcare suffers disproportionately[2]. The United Nations Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules) explicitly recognize the need for equivalence of care in prisons and insist on medical ethics regardless of incarceration status[3].

Prisoners, although deprived of liberty, retain all other human rights including access to adequate healthcare[4]. Viewed through a historical lens, the deep intertwining of incarceration, medicine, and state power becomes apparent. Performing medical experiments on prisoners without their consent in concentration camps was a reflection of their ultimate dehumanisation. The lack of healthcare services and overcrowding contributed

[1] World Health Organization (2013). The economics of social determinants of health and health inequalities: a resource book.

[2] Gülay Çetin v. Turkey (2013) European Court of Human Rights, Application no. 44084/10.

[3] United Nations (2015). United Nations Standard Minimum Rules for the Treatment of Prisoners. The Nelson Mandela Rules. Adopted by UN General Assembly resolution 70/175.

[4] Kalashnikov v. Russia (2002) European Court of Human Rights, Application no. 47095/99.: The applicant, a Russian national and President of the Northeast Commercial Bank, was detained under conditions that severely violated his human rights, including overcrowded, unsanitary cells with inadequate facilities and exposure to infectious diseases. The Court found that the prolonged detention, combined with these deplorable conditions, amounted to degrading treatment and violated Articles 3, 5 § 3, and 6 § 1 of the European Convention on Human Rights. The applicant suffered from sleep deprivation, skin diseases, and psychological suffering due to constant noise, lighting, and poor ventilation, especially when detained with inmates suffering from contagious illnesses like tuberculosis and syphilis. Although there was no evidence of an intent to humiliate, the Court emphasized that the conditions caused significant mental and physical suffering, diminishing the applicant's human dignity, and that the lengthy pre-trial detention (four years and 10 months) and delays in proceedings further breached his rights.

directly to prisoner and detainee deaths, effectively serving as a form of execution (Lichterman, 2005: 408). Following World War II, developments such as the Nuremberg Code sought to codify protections against such abuses. Certain practices became theoretically "illegal" in a very broad sense within the international community, criminalising governments, collectives and individuals, whether military or civilian, and covering the commission of crimes both in an individual basis as well as in a collective sense[5]. Modern penal systems still struggle with legacies of exclusion and control, particularly in underfunded healthcare services. Also, the prison population is growing, and prisoners have considerable health problems. Prisons are designed with the aims of punishment, correction and rehabilitation in mind, and these goals may conflict with the aims of healthcare (Watson et al., 2004). The economic factors underlying penal health are often obscured by bureaucratic rationality and austerity budgeting too.

Contemporary prison populations are disproportionately made up of individuals from disadvantaged backgrounds. In reality, up until the end of the eighteenth century, places of confinement served mainly to detain those suspected or found guilty of crimes to await the administration of their sentence, which consisted then in various corporeal punishments (whipping, pillorying, burial, branding or mutilation, being put to death with or without torture), supplemented by banishment and condemnation to forced labor or to the galleys. Reminding ourselves that the prison is a very young institution on the scale of the history of humankind is to stress that its growth and permanence are not a foregone conclusion (Wacquant, 2001: 403). The generalised increase of carceral populations in advanced societies is due to the growing use of the penal system as an instrument for managing social insecurity and containing the social disorders created at the bottom of the class structure by neo-liberal policies of economic deregulation and social-welfare retrenchment. (Wacquant, 2001: 401). According to reports by national human rights institutions and ombudspersons, prison healthcare frequently falls below minimum standards, especially in mental health services, access to specialists, and emergency care[6]. The ECtHR has handed down numerous judgments, including in the cases of Gülay Çetin v. Turkey and Dorneanu v. Romania, which illustrate systemic neglect constituting inhuman treatment under Article 3 of the ECHR [7, 8].

[5] Robert H. Jackson Center, The Influence of the Nuremberg Trial on International Criminal Law, https://www.roberthjackson.org/speech-and-writing/the-influence-of-the-nuremberg-trial-on-international-criminal-law/, accessed on 10.04.2025.

[6] World Health Organization (2010) Health systems financing: the path to universal coverage.

[7] **Gülay Çetin v. Turkey,** *European Court of Human Rights, Application no. 44084/10, 2013.*

[8] **Dorneanu v. Romania,** *European Court of Human Rights, Application no. 55089/13, 2018.*

Health inequities stem in large part from government policies and practices that distribute power and resources – such as housing, law enforcement, education, employment, environmental amenities, and health services – inequitably (Fleming et al., 2021). Economic crimes, ranging from procurement fraud to embezzlement, directly affect the availability and quality of healthcare in prisons by misallocating public funds. Such crimes erode the fiscal base required for example for staffing, infrastructure and essential medical supplies. Budgetary opacity often conceals these deficits from public scrutiny, leaving inmates at risk of receiving substandard care. People who have been incarcerated are more likely than those who have not to have negative health effects such as death from accidents, substance use, HIV, liver disease, and liver cancer (Fleming et al., 2021). Collaboration between legal and healthcare professionals is essential to upholding the integrity of healthcare provision within justice systems. The way courts adjudicate economic crime cases can either legitimise or challenge patterns of exclusion and inequities in the system (McCormack, 2021: 175). This includes their ability to recognise structural consequences. This is important for sentencing and interpreting policy. The justice system entrusts judges with the enormous responsibility of making judgements that affect every aspect of people's lives. The quality of the system in which they operate determines their capacity to do justice in that role (McCormack, 2025: 189).

5. Possible impacts on marginalised communities

According to sociologist Loïc Wacquant, in neoliberal states, the dismantling of welfare systems is accompanied by the intensification of punitive measures. This dual process disproportionately affects marginalised communities, who lose access to health and social services, instead facing increased incarceration. Wacquant terms this the "penal state" where social problems are managed through punishment rather than care (Wacquant, 2001: 410). The absence of accessible services serves to perpetuate cycles of poverty and exclusion. In such environments, there is often a decline in the accessibility of healthcare, which has a detrimental effect on public health (Fleming et al, 2021). Fleming (2021) highlights two divergent ways in which government policies are distributing resources: (1) the government spends substantial amounts of money on policies that have been shown to harm health, and (2) policy-driven deprivation of critical resources causes harm to population health. (Fleming et al, 2021). By neglecting the health needs of marginalised groups, states contribute to their invisibility and erasure from public life, thereby reinforcing existing inequalities. In the case of Gülay Çetin v. Turkey, for example, the European Court of Human Rights ruled that there had been a violation of Article 3 of the European Convention on Human Rights due to the failure to provide adequate medical

care to a detainee with cancer [9]. This suggests the need for criminal policy reforms to prevent the indirect use of institutional healthcare as a tool of exclusion or punishment (Wacquant, 2001: 401–412). Prison overcrowding can be solved in a number of ways, including through compensation, fine, mediation, remission, community service, caution, probation, electronic monitoring and house arrest, absolute or conditional discharge, etc.[10]. The criminalisation of poverty and illness can also be prevented by the strengthening of social and health systems. This, in turn, has the effect of reducing the number of unnecessary incarcerations. "The tightening of the penal policy and the application of the repressive concept does not give the expected results in the prevention of crime, on the contrary, crime is increasingly present in the most diverse and brutal forms of manifestation, and the prison population has grown" (Igrački, 2024: 372). In a "broader sense, the proper functioning of society, education, training, social institutions, etc. also serve the purpose of crime prevention" (Elek, 2024: 284).

6. Healthcare as a Penal Function under Structural Deficits

In *Discipline and Punish*, Michel Foucault argues that healthcare institutions, prisons and schools, are mechanisms of social control and power. (Foucault, 1977: 185). When prisons are overcrowded and healthcare systems are failing, medical institutions may take on penal functions by failing to help or serve people. Inadequate care and coercive treatment can serve as mechanisms of punishment or containment rather than as remedies. A concerning resurgence of institutionalization under the guise of modern mental health care, with policymakers expanding state control through involuntary commitments, forced treatments, and the creation of "wellness farms" that echo historical systems of confinement and exploitation. These efforts serve to increase surveillance and detention of marginalised communities, including the disabled, unhoused, and racialised populations, often obscuring the violent legacy of institutionalisation. (Jensen, 2025: 2).

[9] Gülay Çetin v. Turkey, European Court of Human Rights, Application no. 44084/10.: The European Court of Human Rights' ruling in Gülay Çetin v. Turkey marked a significant development by explicitly recognizing discrimination between remand and convicted prisoners, particularly regarding access to protective measures for those with serious illnesses. The Court found that Çetin, who suffered from metastatic gastric cancer, was subjected to inhuman and degrading treatment due to her continued detention and the denial of release or medical parole solely because she was in pre-trial detention, despite her worsening health. This case illustrates how a state can deny access to adequate healthcare and suitable alternatives to detention, resulting in inhumane and degrading treatment.

[10] UNODC (2013). Handbook on Strategies to Reduce Overcrowding in Prisons, United Nations. Available at: https://www.unodc.org/documents/justice-and-prison-reform/Overcrowding_in_prisons_Ebook.pdf, accessed 21.06.2025.

The World Health Organization and the European Committee for the Prevention of Torture have observed and reported such patterns, suggesting that institutional conditions may reproduce inequalities despite formal legal safeguards[11].

Incarcerated individuals constitute a uniquely vulnerable group in terms of access to healthcare. The legal status of incarcerated individuals, the closed nature of prison institutions and their dependency on state-provided services mean that their right to healthcare is both essential and precarious (Wilper et al., 2009). These dynamics are particularly evident in Eastern and South-Eastern European states, where welfare systems are being restructured amid limited resources and ongoing legal fragmentation. Economic crimes that deplete public funds, such as tax evasion and budget fraud, have a direct impact on the allocation of resources to prison healthcare systems (Stuckler et al., 2010).

Even in systems with technologically advanced healthcare infrastructure, systemic exclusion can occur in the absence of social safety nets. For instance, access to quality care may depend on financial capacity, disadvantaging economically marginalised groups disproportionately. This pattern confirms that exclusion is not merely a function of institutional capacity or infrastructure quality, but of policy design. The inability to afford healthcare, despite its availability, perpetuates socioeconomic inequalities and undermines the universality of health rights. When this logic is translated into custodial settings, it can manifest as selective neglect or differential standards of care based on status or affiliation.

Studies indicate that prison healthcare is often underfunded, understaffed and removed from national health policy priorities (Wilper et al., 2009). The result is a systemic failure to provide timely, adequate and continuous care. In this context, economic crime is not merely an abstract financial harm; it translates into tangible health disparities within prisons (Stuckler et al., 2010).

This makes the penal environment a critical field for examining the social consequences of economic crime, particularly in relation to marginalised groups. Ageing prisoners, for example, are often referred to as "the most care demanding and expensive group to house in prison" (Milićević, Ilijić according to Doron & Love, 2013). These observations are particularly pertinent in Southeast European contexts, where underinvestment and fragmented social protections exacerbate the vulnerabilities of prison populations.

[11] Council of Europe, 21st General Report of the European Committee for the Prevention of Torture, CPT (2023).

7. Conclusions

Mismanaging state budgets significantly exacerbates inequality within the justice and health sectors. When governments fail to allocate public funds effectively, essential services such as healthcare and social support systems receive insufficient funding, which disproportionately affects marginalised populations. Stuckler and Basu (2013) have directly linked austerity measures and poor fiscal planning following economic crises to increased mortality and diminished access to care in vulnerable groups (Stuckler, Basu, 2013). Similarly, Farmer (2004) describes poor government prioritisation in budgetary processes as a form of structural violence, whereby entire social groups are denied basic human rights, such as health and legal protection. (Farmer, 2004: 40). Failing to allocate sufficient resources to penal and health systems can transform these institutions into mechanisms of exclusion rather than support.

Paul Farmer (2004) describes "structural violence" as institutionalised arrangements that put populations at risk and prevent them from accessing basic rights, such as healthcare. (Farmer, 2004: 40). During the COVID-19 pandemic, this framework gained renewed relevance. In Hungary, the elderly was particularly affected by the limitations imposed by the pandemic on their use of the healthcare system, access to hospitals (Elek, 2023: 396). Bambra et al. (2020) showed that existing health inequalities worsened outcomes in disadvantaged communities, with the pandemic acting as a catalyst that intensified structural neglect (Bambra et al., 2020).

Economic crime, particularly tax evasion, corruption, and illicit financial flows, undermines the ability of states to provide universal access to healthcare. According to Cobham and Janský (2018), tax avoidance leads to significant global revenue losses, which in turn erode public financing capacities (Cobham & Janský, 2018). These losses have a disproportionate impact on the health sector, where underfunding results in restricted access for low-income and vulnerable groups.

Gaspar (2019) contend that equitable healthcare necessitates robust domestic revenue mobilisation. When corruption and shadow economies erode the tax base, essential health services become inaccessible to large sections of the population (Gaspar et al., 2019). This structural weakening was especially evident during the COVID-19 pandemic, as underfunded health systems struggled to manage the crisis (Gaspar et al., 2019).

Additionally, the World Health Organization (WHO, 2010) has recognised that illicit financial practices severely hinder efforts to achieve universal health coverage by

depriving health systems of sustainable financing[12]. This also demonstrates how economic crime impedes the realisation of health as a human right. Efforts should be intensified to trace and prosecute economic crimes that compromise equitable public health systems. While increasing health funding, financial transparency and combating economic crime are necessary to ensure adequate public funding systems, such measures must be accompanied by robust safeguards for human rights and equality. Health systems must not be allowed to function as a social exclusion (Farmer, 2004: 40) or control. Public health policies should be explicitly guided by principles of dignity, non-discrimination, and equitable access.

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