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The Human Right to Health

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Wheras Ethics is the proper language of Medicine, Human Rights is the proper language of Public Health

In public health, we uncritically assume scarcity of resources without asking why scarcity.

-WHO comes with technical advice, the World Bank comes with money….countries usually prefer the money.

1. The human right to health: some precisions

1. The human right to health (RTH) is an increasingly current discussion issue in international and national health corridors; it must be kept center stage, especially in the context of the ongoing millennium development goals (MDGs) discussion. Much new is being implemented there and should thus be followed.

2. As a reminder, the RTH is about processes–and much of our MDG discussions still only look-at and target outcomes. Without the proper participatory processes, outcomes may mean nothing, especially for sustainability (i.e., MDGs: what after 2015?).

3. So, what processes should the MDGs entail to be RTH compliant?: citizen monitoring of local public and private health services and the generation of public information about it; beneficiaries collectively providing feedback on service performance and demanding specific reforms via voice and dialogue; negotiation of issues about the services provided between service users, service providers and others as needed; demanding answerability by agencies and service providers and concrete responses from relevant officials.*

> *: Health agencies always claim they have to reach a consensus before moving, and consensus always gives the most powerful the power of veto. Any conclusion or subject or terminology that may offend the powerful groups seated at the table, and who have to approve the report or policy, must be dropped. WHO does not escape this profile; it fails to hold up people's health as a mirror which reflects the nature of the larger political-economic system. But we know the process by which this failure occurs and the agents responsible in each case. We must denounce not only this undemocratic process, but also the forces that exert this control (or pressure behind the scenes). As public health workers and human rights (HR) activists we can and must do so. (V. Navarro, A. Shukla)

4. By now, there are growing numbers of case studies of the application of the HR framework to health; this transcends the mostly theoretical discourse of the recent past where we did not have concrete applications to refer to.

5. Furthermore, the RTH cannot be separated from its links with PHC, a topic given prominence in part 2 of this Reader. Ergo, increasing room should be made in health fora (workshops, conferences, courses) for the discussion of the RTH as it relates to primary health care (PHC), for instance, among other, how the RTH touches issues of genuine community participation, how it empowers claim holders and duty bearers in PHC settings, why access-to and universal coverage-of PHC are central issues, and what accountabilities are implied in PHC work.

6. The RTH is also inseparable from discussions on health systems. It calls for profound changes in these systems. The transition from health sector reforms as promoted by the World Bank (and 'accepted' by many poor countries) to a more equitable system has been poorly addressed, i.e., how do we get from the here to the there. A roadmap is emerging and needs to be discussed in the same fora, national and international.

7. It is well known that gender inequality, HIV and AIDS and maternal morbi-mortality are intimately inter-related; they all persist when human rights are being violated and discrimination prevails. While these all require health sector responses, they also require complementary responses in other sectors to address the underlying structural and social inequalities behind HR violations. (UNDP)

8. Structural-interventions-the-RTH-asks-for bring about positive health outcomes in many ways:

> · they alter the context in which health is produced: for example, addressing economic marginalization and food sovereignty issues among people who live in poverty, among minorities and among migrants;
>
> · they address these people's socioeconomic conditions, as well as the legal and policy context and cultural norms they live under; and
>
> · they can lead to sustained progress, particularly where those who were disempowered by the existing structures become directly involved in determining the changes needed for an equal enjoyment of all human rights. (UNDP)

9. Seen from this RTH perspective, claim holders are thus expected to become 'users and choosers' and 'makers and shapers', i.e., claimants of public space…The question is: As health workers, are we working towards making this come true?

2. Neoliberalism and health from a human rights perspective

10. The mantra we keep hearing from the backers of neoliberal policies is: "Those who can pay should pay; cross-subsidization will follow". But we know this is basically an empty slogan (…remember 'trickle down'?…).

11. Neoliberalism first and foremost allocates resources to disease-control-interventions in the public sector, on the one side, and much more to comprehensive-health-care options in the private sector on the other. ** No denial possible here. (J.P. Unger) This could not be further from the HR-based approach (HRBA) –and that is where neoliberal ideology and the HR-based approach clash.

> **: You have all heard it. They tell us that medicine is a fight of life against death. If it were so –as some erroneously think– we should be telling people: we won't give you syrups for your bronchitis, because you really need to breathe fresh air; we won't give you tranquilizers for your neuroses, because you should work on the causes of the same; we won't give you vasodilators for your spasms, because you should eliminate traffic jams and learn to live with the attitude of your boss; we won't give you medicines for your liver, because you should not be eating artificial foods; we won't give you vitamins, because you should be eating fruits; we won't offer you our patient understanding, because you have to find love and understanding in wo/men and in solidarity with your compatriots; we won't sign sick days for you, because you have to shorten your work week and build cities in which you do not have to drive for hours or ride crowded buses to get to work. We should behave like this if health is to be really oriented to conserving life. [We further fabricate heart attacks and EKG machines to diagnose them, and sections of hospitals to take care of them. We fabricate lung cancers and build operation rooms to operate on them. In reality, our behavior has its logic: the logic of the market, of competition. Building on a lifestyle with less stress that would reduce the chances of a heart attack would mean decreasing competition in our lives: For what reason don't we do this?]. (L. Conti)

12. In short, leaving provision of health services to the market means that the poorest people must put aside a larger share of their incomes for fees for health services thus increasing inequalities in access and in income.

13. A final thought here: Doctors possess the ultimate of market power as demonstrated by their ability to induce a demand for profitable services, for all sorts of (often expensive) medicines and for expensive tests and technologies. (W. Hsiao) Right?

3. The equity perspective in right to health work

> -Individuals are each entitled to a certain level of achievement in the game of life, and anyone failing to reach this level has been hard done by the prevailing system. (A. Sen)
>
> -Deaths and ill-health are not randomly distributed in the world. (V. Navarro)

14. Rapidly growing inequalities in health status indicators between and within countries uniquely characterize the current global situation.

15. Disappointingly, we too often overlook the fact that it is not inequalities per-se that kill, but rather those-who-benefit-from-the-inequalities-they-have-imposed that kill those-who-suffer-from-the-same. (V. Navarro)

16. Amartya Sen has also elaborated on this issue; he tells us:

> "Let us be realistic: Equality, as an abstract idea, does not have much cutting power; the real work begins when we have to specify what it is that needs to be equalized. The central step, then, is the specification of the space in which equality is to be sought. Health equity must thus be made central to the understanding of social justice. This, for example, means that equity in the distribution of health has to be incorporated and embedded in the larger understanding of justice. In that sense, an illness that is not prevented and/or goes untreated for social reasons has a negative relevance to social justice,

simply because fairness requires that no group be discriminated.

As we all know, there are gross inequalities in health achievement that arise not from irremediable health preconditions, but from a lack of economic policy, social reform or political engagement with the sector.

As a corollary, we must keep in mind that Distributional Indifference is a serious limitations of the disability-adjusted life years (DALYs) approach. This distribution indifference means that a disabled person, or one who is chronically ill –and is thus disadvantaged in general– also receives less medical attention for other ailments when trying to minimize DALYs; and this has the effect of adding to the relative disadvantage of a person who is already disadvantaged. Equity considerations in the provision of health care are simply not represented in DALYs. Period.

Ultimately, health equity is embedded in the broader framework of overall equity.

It is the overall distribution of resources that ultimately determines the state of people's health. This addresses the fact that differences can be (and are) very large between different social classes, but can also be large between the sexes (e.g., difference in life expectancy at birth between men and women in the UK is even greater than that between social classes).

The question then is: Should this understanding guide the allocation of health care resources? Equity in health care should indeed entail distributing care in such a way as to get as close as is feasible to an equal distribution of health. But it also entails implementing fair processes that must attach importance to non-discrimination in the delivery of health care –and that is also a HR issue.

Therefore, an adequate engagement with health equity requires that the considerations of health be integrated with broader issues of social justice".

17. As you well know, there is no more inequitable system than the fee for service system; yet the World Bank stubbornly argues that "paying for services confers power to the users". This assumes, without evidence, that the poor can afford and will pay "a modest co-payment". Any illusions that patients may be empowered by fees should be vigorously dispelled by all of us. Poor users excluded by the fees are replaced by wealthier sections of the population who can afford to pay –a backward step for equity and for HR. Conversely, there have been astounding successes where user fees were abolished (notably Uganda). Of all measures tried, user fees are probably the most regressive and ill-advised. Consequently, the continued charging of user fees clearly undermines international HR law.

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Note

Partly based on L. Conti. Estructura Social y Medicina, in 'Medicina y Sociedad'. Ed. Fontanella, Barcelona 1972. p. 296-7; D+C, Vol 35, No.9, September 2008; Globalization and Health: Pathways, Evidence and policy, R. Labonte, T. Schrecker, C. Packer and V. Runnels Eds, Routledge Books, 2009; D. Tarantola et al, Human Rights, Health and Development, Technical Series Paper #08.1, UNWS; Development in Practice, 19:8, 2009; and A. Sen, presentation, York, UK, 23 de July 2001.

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