1.2. Guaranteeing essential health care for all

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Introduction

The tendency to translate expectations and needs into the language of rights is a means of putting these expectations and needs beyond political, cultural or social whims, making them indisputable. Thus, the concept of rights becomes attractive as it strengthens demands and enables them to be claimed. We could say that the reference to rights is important not only because rights guarantee a series of needs and expectations, but also, most importantly, because of the very way they are worded. But are rights always indisputable? We believe that their indisputable nature depends on overcoming a number of problems that regard their justification and the degree of legal recognition achieved.

The keywords "rights" and "human rights" are at constant risk of vagueness, one that may compromise their very effectiveness. The grey area surrounding human rights may concern the definition of their content, their justification, and the corresponding obligations. Perhaps the clearest example is the World Health Organization's (WHO) definition of health, which demonstrates the often structural (and, we should add, convenient) vagueness of the content of rights. In this perspective, health is not merely the absence of disease and infirmity but "a state of complete physical, mental and social well-being". What do they mean by "well-being"? What, if any, are the gradations it encompasses? Who needs to act so that this well-being can be enjoyed and how can it be achieved? These are the key questions when giving legal form to this demand. The minimum gradation of this concept, and consequently of the very concept of health as a right, is to guarantee that every individual has access to basic healthcare regardless of geographical, financial and social barriers, whatever their culture or race.

With this in mind, how can we, and should we, state that health is an essential need legally protected as a human right? To do so, let us take a quick look at the notions of human rights and fundamental rights.

Human right and fundamental rights

Although the two expressions are often used to mean the same thing, in legal terms a distinction should be made:

a. fundamental rights are rights that are recognised as such by a country's legal system within a constitution;

b. human rights are rights to which a person is entitled because he or she is an individual, regardless of his or her relationship with the State; these rights are recognised by the international legal system.

The matter changes, however, if the content of fundamental rights and human rights converges substantially in terms of legal form and guaranteed mechanisms. The former are governed by constitutional guarantees, i.e. structural guarantees linked to the rigidity of the constitution, jurisdictional guarantees, and the right to go to court to have these rights recognised. In this case, legislation is guided by the Constitution. The latter are governed by international protection mechanisms that have reached a higher level of efficacy for certain civil rights, but are still lagging behind for some social rights. Asserting a human right means wishing to safeguard the essential need that it protects and extending it to all human beings, but this involves relying on both national and international legal guarantees. Wherever national institutional support is lacking, however, these legal guarantees are particularly feeble. It is essential to interact with national law to ensure that international standards are effective.

What is the right to health?

In Italy, health is an essential need protected by the national legal system; it is also protected by Article 32 of the Constitution (in conjunction with Articles 2 and 3) and by statutory laws. In this sense, health is a fundamental right. Health is also an essential need protected by international sources, which therefore makes it a human right. In this latter case, there is a wide range of reference sources:

a. soft law, i.e. non-binding legal sources that are in place to indicate a direction and to record programmatic objectives drawn up within the international community: article 25 of the Universal Declaration of Human Rights (UDHR) in 1948; the Declaration of Alma Ata in 1978; the Ottawa Charter in 1986; and article 14 of the UNESCO Declaration on Bioethics and Human Rights in 2005. Article 19 of the United Nations Millennium Declaration in 2000 had an indirect link to the right to health as it referred to some direct and social determinants, to the Millennium Development Goals (MDG), which aimed to reduced mother and child mortality, and to the fight against HIV/AIDS;
b. general sources of hard law, such as the International Covenant on Economic, Social and Cultural Rights (Article 12) in 1966; or the result of the specification of rights, such as the Convention on the Elimination of All Forms of Discrimination against Women (Article 12) in 1979 and the Convention on the Rights of the Child (Article 24.2) in 1989;
c. regional sources of hard law, such as the Council of Europe Convention for the Protection of the Rights and the Dignity of the Human Being with regard to the Application of Biology and Medicine (Articles 1 and 3) in 1997; the American Convention on Human Rights in 1969 and the Protocol of San Salvador (Article 10); or the African Charter (Article 16) in 1981.

The framework of these sources calls for some reflection. On one hand, the sources of soft law define the content of the right to health clearly, setting in within the fabric of socio-economic and cultural conditions; and yet they insist very little on the legal aspect of the right, entrusting its guarantee, or so it seems, to political rather than to legal initiatives. On the other, the approach to health as a right resulting from the sources of hard law is a victim of a dual constraint in that they place the right clearly in the category of social rights and highlight the state-centric aspects of its implementation process. Qualifying the right to health as a social right means that its nature is conditioned by financial resources and political will. The state-centric option prevents the right to health being raised to the level of a human right, despite its internationalization being of vital importance in that some States cannot or do not want to guarantee this right[1].

Additional elements that justify the distinction between different categories of rights (mainly between civil rights and social rights) are the framework of the corresponding obligations as well as the existence, or lack, and the nature of guarantee mechanisms. All rights encompass (for the State and its partners) negative obligations (i.e. the obligation to refrain from adopting conduct that may breach these rights) and positive obligations (i.e. the obligation to ensure these rights are implemented). It seems, however, that negative obligations prevail when regarding civil rights (e.g. freedom of thought and religion); while positive obligations are dominant within social rights. This explains the structural dependence of social rights on political initiatives. Here we see the first chink in the armour; the very nature of rights expresses inviolable needs that protect the dignity and equality of human beings, yet there are some whose implementation is governed by political will. To a certain extent, this result stems from the fact that, when dealing with these rights, legislators are not only required to observe constitutional law (in negative terms), but are also required to implement it and to endow it with tangible, precise content. The corresponding obligations of the right to health comprise mainly positive obligations, which implies that the State must act to create a health system that ensures general access is possible.

The International Covenant on Economic, Social and Cultural Rights

Above we mentioned the International Covenant on Economic, Social and Cultural Rights[2] as one example of hard law. This international treaty, which is considered one of the major human rights treaties[3], was adopted during the United Nations General Assembly in 1996 and was ratified by 142 governments. Some countries, however, including the US and South Africa, have not yet ratified it. The Covenant requires governments to guarantee the right to access to the essential needs of human life, such as work, food, health, education and housing. The Covenant deals with health in Article 12, which states the following:

> 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 steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary:
> - the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
> - the improvement of all aspects of environmental and industrial hygiene;
> - the prevention, treatment and control of epidemic, endemic, occupational and other diseases;
> - the creation of conditions which would assure to all medical service and medical attention in the event of sickness.

The United Nations Committee on economic, social and cultural rights, which was appointed to ensure that the treaty deriving from the 2000 report was implemented, underlines how the health of the world's population has changed radically since 1966[4]:

> "Since the adoption of the two International Covenants in 1966 the world health situation has changed dramatically and the notion of health has undergone substantial changes and has also widened in scope. More determinants of health are being taken into consideration, such as resource distribution and gender differences. A wider definition of health also takes into account such socially related concerns as violence and armed conflict. Moreover, formerly unknown diseases, such as Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS), and others that have become more widespread, such as cancer, as well as the rapid growth of the world population, have created new obstacles for the realization of the right to health." "The Committee is aware that, for millions of people throughout the world, the full enjoyment of the right to health still remains a distant goal. Moreover, in many cases, especially for those living in poverty, this goal is becoming increasingly remote. The Committee recognizes the formidable structural […] obstacles […] that impede the full realization of article 12 in many States Parties".

The Committee also comments on the concept of the highest attainable standard of health introduced by the Covenant in 1966.

> "The right to health is not to be understood as a right to be healthy. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, 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. The notion of "the highest attainable standard of health" in article 12.1 takes into account both the individual's biological and socio-economic preconditions and a State's available resources. There are a number of aspects which cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health. Thus, genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky

lifestyles may play an important role with respect to an individual's health. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health". "The Committee interprets the right to health, as defined in article 12.1, as 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".

The Committee, knowing that the restricted financial resources of the poorest countries was an insurmountable obstacle to the Covenant's implementation, underlines two key concepts: a) the basic level of health care to guarantee everybody, and the ensuing fundamental obligations; b) the obligation of the richer States to cooperate with the poorer ones in the implementation of the rights recognised in the Covenant. Both points refer to the Declaration of Alma Ata in 1978:

"While the Covenant provides for progressive realization and acknowledges the constraints due to the limits of available resources, it also imposes on States parties various obligations which are of immediate effect. The Committee confirms that States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care. Accordingly, in the Committee's view, these core obligations include at least the following obligations:

- to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
- to provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
- to ensure equitable distribution of all health facilities, goods and services.

"The Committee drew attention to the obligation of all States parties to take steps, individually and through international assistance and cooperation, especially economic and technical, towards the full realization of the rights recognized in the Covenant, such as the right to health. […] In this regard, States parties are referred to the Alma-Ata Declaration which proclaims that the existing gross inequality in the health status of the people, particularly between developed and developing countries, as well as within countries, is politically, socially and economically unacceptable and is, therefore, of common concern to all countries. […] Depending on the availability of resources, States should facilitate access to essential health facilities, goods and services in other countries, wherever possible and provide the necessary aid when required. States parties should ensure that the right to health is given due attention in international agreements. […] Accordingly, States parties which are members of international financial institutions, notably the International Monetary Fund, the World Bank, and regional development banks, should pay greater attention to the protection of the right to health in influencing the lending policies, credit agreements and international measures of these institutions".

In its updated interpretation of the 1966 Covenant, this UN Committee report highlights two key features:

a. it abandons, or a least severely softens, the state-centric vision of the right to health and proposes a perspective of social justice that tends towards global as it directly involves richer countries and international financial institutions;
b. it does away with the idea of deadline-free progression in implementing this right, making it obligatory, with immediate effect, in order to meet the most vital requirements (provision of primary health care).

It was probably no coincidence that in December 2001, the year after the Committee had made its comments, WHO published its report *Macroeconomics and health: investing in health for economic development* (MH)[5], which contained its recommendations for a new intervention strategy for the improvement of health in poor countries. These recommendations seem to encompass the recommendations made by the UN Committee. The report proposes:

a. defining a primary health intervention package that is universally accessible aimed at slashing premature mortality in poorer countries, which causes 8 million deaths per year;
b. financing this package by having the poorer and richer countries sharing this commitment.

The MH report states that it is possible to improve health in the poorest countries in that they are mainly afflicted by a small number of diseases for which effective intervention already exists. Intervention, however, does not reach the poor; one reason lies in the inefficiency of the health care systems and in corruption, but the main problem is the lack of financial resources in low-income countries and their unequal distribution in medium-income countries. What is needed is a shock strategy based on huge investments in the health systems of poor countries and in global public assets, one that will help to reduce poverty and boost economic development. The governments of poor and rich countries alike have been asked to find the resources needed to finance the health of poorer nations. The governments of poor countries play a key role in financing their health systems and therefore need to review expenditure priorities so that the share of national wealth invested in health can be increased and the efficiency of the public sector improved. The governments of richer countries need to review the priorities of their international development policies and to triple the financial resources they currently invest in improving the health of the poor.

The MH report states that the health care systems of poor countries need strengthening most at Primary Health Care (PHC) level so as to facilitate health care access to the poor. The report proposes that each country draws up a package of basic intervention that can be made universally available and free of charge. It also includes a list of prevention and treatment activities for the following conditions: HIV/AIDS, malaria, tuberculosis, ante and postnatal care, the causes of infant mortality including measles, tetanus, diphtheria, acute respiratory problems, diarrhoea, malnutrition, other illnesses that can be prevented with a vaccination,

plus smoking-related pathologies. Despite calling to strengthen PHC, the report is a blend of Selective PHC and the packages of basic treatment proposed by the World Bank.

The MH report estimates that the poorest countries need an annual amount of 35 dollars per capita to guarantee universal access to these packages, an amount that includes the costs of strengthening the health care systems. This amount is much higher than the public health expenditure per capita of countries in Sub-Saharan Africa (generally lower than 10 dollars per capita) and India (6 dollars per capita). According to the report, in order to reach this objective, it would be necessary to progressively increase overall public health care expenditure by 57 billion dollars by 2007 and by 94 billion dollars by 2015. These additional health care resources would be contributed partly by poor countries (35 billion dollars by 2007 and 63 million dollars by 2015) and partly by rich countries, who are supposed to contribute the balance (about 22 billion dollars by 2007 and 31 billion dollars by 2015).

In 2000 the United Nations launched the Millennium Development Goals (MDG), previously mentioned as a source of soft law, in order to slash extreme poverty and to improve the world's health conditions by 2015 (i.e. reduce maternal and child mortality, and fight the main endemic diseases: AIDS, tuberculosis and malaria). In order to achieve these ambitious goals, resources are going to be needed: a lot of resources. The main need however will be the political determination of the target countries and the international community. Jeffrey Sachs, coordinator of the MH report, calculated in another publication that Public Development Aid (PDA) would need to provide 52 billion dollars in 2006 to fund the MDG, an amount that would reach 110 billion dollars in 2015 (about one third of these funds would be geared towards achieving health objectives)[6]. Sachs observes, however, that PDA funds these objectives with much less than necessary (only 16 billion dollars in 2002) and that its policies and priorities are not consistent with these objectives. Halfway towards the MDG, the results for the poorest countries, and for Sub-Saharan Africa in particular, are disconcerting; for some indicators, such as maternal mortality, they are catastrophic in that mortality has increased instead of dropping by three-quarters as planned.

It is also worrying to note the enormous gap between the resources needed to provide basic levels of treatment and/or to obtain a minimum health result and the effective availability of the resources for those objectives. If we examine public health expenditure in poor countries, which includes donor contributions, it shows no overall sign of improvement because the tens of billions of dollars that were supposed to finance primary health care packages and MDG have not actually materialised. Furthermore it is alarming to note the vast divide between what are almost unanimously considered to be good practices to be implemented in the health policy of the poorest countries (i.e. strengthen the health system, invest in human resources, and eliminate financial barriers to access to services) and what is imposed by international agencies (vertical development programmes, exodus of health care staff towards the private sector or abroad, and user fees).

Within this context, the repeated attempts to define universally accessible essential health packages appear to be an exercise that is not only vain – a mere façade –

but a grotesque one to boot. The situation has been like this since 1993 when the World Bank published its Investing in Health report, which launched a series of concepts including Burden of Disease and DALYs (Disability Adjusted Life Years), Cost Effective Interventions and Essential Health Package[7]. The aim was to measure the burden of disease generated by individual pathologies; highlight the economic damage it caused; draw up a table according to cost/effectiveness ratio for the individual diseases (e.g. antenatal and birth care, 38-63 dollars per year of life saved; all of the vaccinations plus Vitamin A supplement, 15-22 dollars; chemotherapy for tuberculosis, 1-4 dollars); and propose an essential intervention package, including the costs per capita (14 dollars per capita). The rationale behind such a process is clear: if diseases, especially those that affect people of reproductive age, cause economic damage, interventions to keep people healthy or heal them are a financial investment. The MH report, with the telling sub-title "Investing in health for economic development", follows the same logic, although it does provide for a much more generous essential intervention package (35 dollars per capita). Had this logic been put into practice, there would have been some improvement in health service accessibility. In the 1990s, the public health care expenditure of poorer countries would have doubled and in recent years quadrupled. Instead nothing was done. On one hand piles of documents were produced to measure burden of disease, DALYs and cost-effectiveness, on the other there was not even the slightest sign of a minimum package of universally accessible free interventions. Instead the situation actually worsened. On one side stood the vertical programmes promoted by the numerous global partnerships, on the other were the macroeconomists who wanted to ensure that the ceiling for public health expenditure was kept at the disgraceful levels that we know all too well (below 10 dollars per capita); all of this means that every new dollar invested in vertical programmes is subtracted from the already meaningless expenditure on PHC.

World Health Insurance

By using the MH report's recommendations, some representatives of Médecins Sans Frontières in Belgium and Great Britain launched a proposal to set up a sort of World Health Insurance[8] based on the following elements:

1. the MH report established 35 dollars per capita per year as the annual minimum level of public health funding needed to ensure all citizens have access to essential care;
2. according to the Abuja Declaration, which was undersigned by heads of African states in 2001, all countries should allocate 15% of public expenditure to health (most African nations allocate much lower amounts to health);
3. countries which have adhered to the previous point, but cannot manage to reach the annual amount of 35 dollars per capita to public health expenditure should receive supplementary funding from the international community;
4. it was calculated that 47 countries would need supplementary funding for an overall annual amount that would be in the region of 30 billion dollars;

5. the burden of this funding would fall onto the 40 richest countries (according to the authors' calculations Italy would have to pay 1.38 billion dollars).

Example:
a. in 2004 Burundi had an annual public health expenditure of 1 dollar per capita;
b. the Burundi government allocated only 2% of its public expenditure to health;
c. if the government were to allocated 15% of its public expenditure to health, then annual public health expenditure would rise to 7.5 dollars;
c. to reach 35 dollars per capita per year, the international community would have to pay the difference to the Burundi government: 27.5 dollars per capita x 7.6 million inhabitants = 209 million dollars per year.

Return to Alma Ata

Today, all of the countries in the world, including the richer ones, have to face the problem of juggling scarce resources to manage a health system with a vast array of needs. These resources are even scarcer in poor countries where efficient allocation is needed to establish priorities and limit services to the ones that will actually provide the maximum benefit to the population health is an act as painful as it is inevitable. There is however a world of difference between macroeconomists compiling a DALY-based package of essential services at a table (an exercise that has proved utterly useless) and the recommendation in the Declaration of Alma Ata which states that "Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford […]"[9].

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