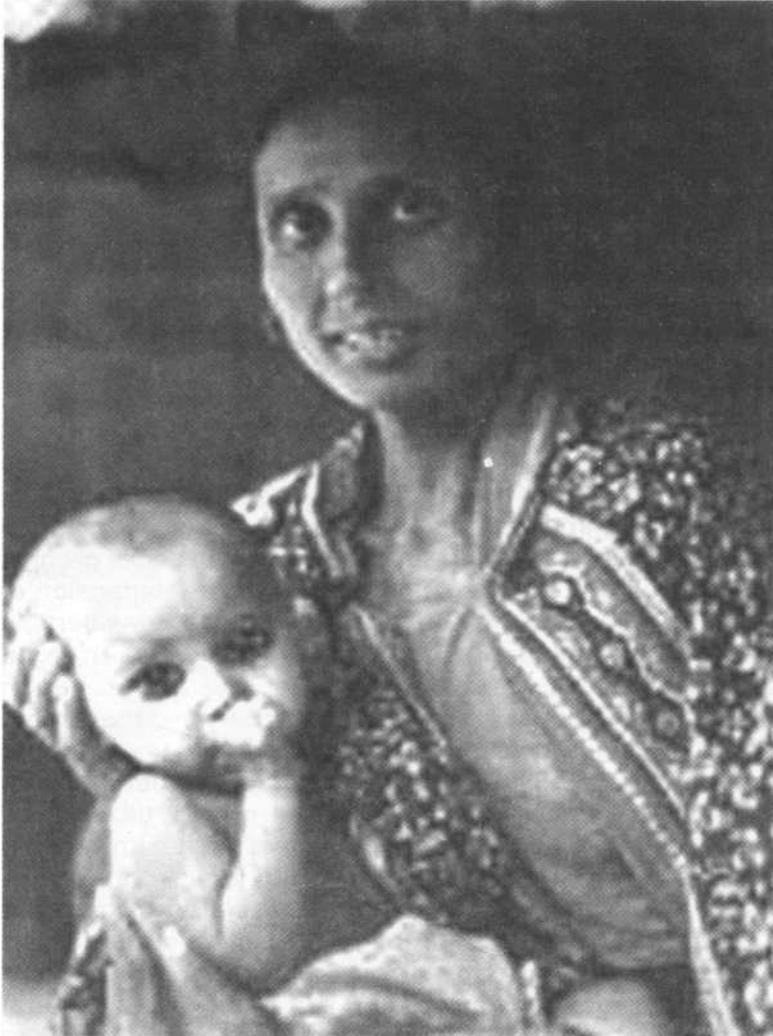


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Tracing Human Rights in Health

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The Experience of Developing Countries in Implementing the Right to Health: The Road Ahead

Developing nations, the groups of nations defined by their low level of per capita income share some similar experiences. They gained independence from the colonial powers in the period succeeding the Second World War. Colonial health coverage was uneven and was geared to serve the strategic interests of the colonial empire, rather than the health of the population in the colonies. No uniform policies were developed with regard to traditional medicine. Colonial medical services augmented medical knowledge and discovery and control of tropical diseases. In the post independence period, in the developing countries there was a demand for curative services. Before the Alma Ata Declaration in 1978, the health policies of these countries reflected the colonial bias. The health system was skewed in favor of the urban areas. There was a shortfall of preventive services. Events

such as the Asian fiscal and monetary crisis of 1998 have had a deleterious effect on the government spending on health. .

The large inequalities in health outcomes for the developing countries do not just reflect different health preferences or needs. They arise due to the constraints in the ability of the individual to achieve good health. Ethnicity, race and location also influence the health outcomes of the developing countries. In South Africa, statistics have shown that the infant mortality rate in South African Blacks is 5.5 times greater than the Whites. In rural China, the life expectancy is six years lower in contrast to the urban areas. A lack on information related to the prevention and the treatment of diseases has inhibited the realization of health for all.

Malaria kills nearly one million children in Africa annually. Empowering mothers to take action at home is a cost effective way of curbing the disease. In the Tigray region of Ethiopia, mothers

were selected from the community, to educate other mothers about the symptoms of malaria. They were provided chloroquine and information on how to administer the drug.⁴ By educating the mothers regarding the symptoms and the cost-effective measures of prevention, Tigray showed the way forward, and there was a fall in under-five mortality by 40%. On October 1977, Ali Maow Maalin, a 23 year old cook living in the town of Merca, Somalia developed smallpox. Vaccination teams immediately descended on the town of Merca and in a span of 3 weeks had vaccinated over 50000 people. Between 1977 and 1979 the WHO initiated smallpox surveillance throughout the Horn of Africa, eradicated the last vestiges of the disease. In 1967, when the program of smallpox eradication was started, approximately 15 million people died of the disease. The program of smallpox eradication cost the WHO \$300 million. The intensified program of smallpox eradication highlights the fact that the eliminating the burden of disease has become affordable for the poorest countries on earth.⁵

Investments in health augment the national income of the developing countries as illustrated by the Sri Lankan Malaria Eradication Program. The near eradication of malaria during the period from 1947 to 1977 correspondingly witnessed a growth in the national income by 9% in 1977. The cost of the program was \$ 52 million compared to the \$ 7 billion gain in national income.⁶

In the Indian Subcontinent, which includes Pakistan, Bangladesh and Sri Lanka, with the notable exception of Sri Lanka, the Bhore Committee report provided the blueprint for the development of health policies in the post independence period. In Sri Lanka, the public health system enjoyed widespread support. According to Mills public action and state responses had politically and socially constructed healthcare as a public good and as a basic right to be enjoyed by all citizens. From the time of independence, the Sri Lankan government had provided for universal and free welfare services that included the provision of free rice, education and healthcare to all its citizens. Scholars have commented that the healthcare system in Sri Lanka received support across the social groups. From 1945 to 1960, there was an expansion of the public health services with a considerable emphasis on maternal and child health, food security and expansion of the public health services at the primary, secondary and the tertiary levels of care.⁷ The public health expenditure was 5.5% of total government expenditure in 1977, which declined to 3.2% in 1981, till it peaked to 6.5% in 1989.⁸ In Sri Lanka the health services were evenly distributed with good connectivity. However, the chief concern related to the right to health realization in Sri Lanka is the indirect costs in terms of transportation, which are a cause of concern for the poor. The structural

reforms programs were implemented in the Sri Lankan economy in the late 1970s and all the universal public health programs became targeted ones.

As far as Pakistan and Bangladesh were concerned healthcare was determined by the political contexts of the two countries. During the 1960s the healthcare investments were largely skewed in favor of West Pakistan. The rate of growth of public hospitals for West Pakistan was 16% from 1959-1966, whereas for erstwhile East Pakistan it was 7 percent.⁹ The health services were underdeveloped in former East Pakistan, now known as Bangladesh. After independence, the government of Bangladesh



assumed state responsibility for health. The regimes of Mujib ur Rehman and Zia ul Haq invested in public health services. It was during the Ershad regime that the famous drug policy of Bangladesh which gave a stimulus to the traditional systems of medicines was passed. The percentage of public spending on health has shown a decline.¹⁰ The health policy document of Bangladesh in the 1990s was based on the World Bank prescription and from the health policy document it becomes clear that the state is unable to provide for the health services. In Pakistan, the investments in public health have been minimal in the post independence period and have shown an urban bias. Government expenditure on public health has never crossed 1.3% of the GNP and there has been a steady decline as far as the public health spending is concerned. The numbers of unemployed doctors have been rising. According to one estimate, 45% of the population does not have access to basic health services. According to Taylor Associates, only 18% of the public health services are located in the rural areas.

Out of the pocket health expenditure is the extant feature in many low income countries) In Vietnam, prior to the establishment of the social insurance in 1998, 30% of the poor households' income on non food budgets went towards health costs, whereas the richest 20% spent only 15% of the non food budgets on medical expenses.¹¹ In Cambodia, a single hospital could absorb as much as 88% of an average household's expenditure. In Thailand, in 2002 the Government introduced a 95 Baht scheme aimed to guarantee healthcare to every Thai citizen. It combines previous health insurance schemes targeted at the poor and allocates the budgetary resources to the providers of care on a capitation basis.¹² The tuberculosis control program in China is an example of how the charging for the provision of public health services can lead to failure of public health program.¹³ In the 1960s, China had made considerable progress in the eradication of tuberculosis due to the long-term free antibiotic therapy made available at the health centers. However, in the year 1981, the government began to levy user fees and the repercussion was that the poor opted out of treatment, as a result the death toll due to tuberculosis had risen to 3,60,000 in the early nineties, (the developing countries have limited resources to provide large risk pools to cover vulnerable groups. They face a trade-off between providing a package of healthcare and extending financial protection?)

dated 6th July 1991 contains health related provisions. *Article 17* deals with the realization of right to health. *Article 44* of the Columbian Constitution states that the rights of children have priority over all others.¹⁴ The Constitution of China states that (Chapter 1, Article 21) the state develops health services, promotes modern and traditional Chinese medicine and supports the establishment of the medical facilities by the rural collectives. The state promotes mass sanitation activities of a mass character to promote people's health. *Article 21* of the Constitution of the People's Republic of China further states that the state develops physical culture and promotes mass sporting activities to promote people's health.

The **Constitution of the Republic of Costa Rica** dated 7th November 1949, has the following provisions related to health:¹⁶ *Article 21* recognizes the inviolability of the right to life. *Art. 46* states that the consumers of healthcare are entitled to protection, inter alia their health and environment and receive truthful information. *Article 50* of the Constitution of Costa Rica states that every person has the right to a healthy and ecologically balanced environment and right for redress in case of any damage caused.

The **Constitution of the Republic of Niger** contains the following Health Related Provisions:¹⁷ *Title II* deals with the Rights and duties of the human person. *Art. 11*, states that everyone has the right to life, health, safety, mental and physical integrity and education as conditions laid down by law. *Article 18* of the Constitution, which states that it is the duty of the state to provide for the physical, mental and moral health of the family, mothers and children in particular. *Article 19* of the Niger's constitution states that everyone has the right to a healthy environment. Thus, in the constitutions of developing countries, the right to healthcare is frequently stated, but regarded as general intention rather than legal reality.

Source : www.cehat.org/newp.html

The Constitution of the Republic of Colombia,