

# Health equity in a globalising world: The importance of human rights

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At the start of the century, the proposition that globalisation might endanger health had gained limited acceptance. It was claimed in 2001 that 'globalisation is good for your health, mostly', based on a simplistic analysis in which increased trade was presumed to lead to faster economic growth and, consequently, better health (Feachem, 2001). Today, after the 2008 financial crisis and in the context of growing awareness of the importance of social determinants of health (Commission on Social Determinants of Health, 2008), recognition of the importance of globalisation for health equity has moved into the mainstream. *The Lancet* Commission on Global Governance for Health (Ottersen et al., 2014) began its report by noting that: 'With globalisation, health inequity increasingly results from transnational activities that involve actors with different interests and degrees of power.'

Financial crises are a case in point: they often originate from sources outside a country's borders; their effects are usually felt first and worst by those with no control over the initiating events; and, wherever they occur, they tend to ratchet up intranational economic inequality (Halac and Schmukler, 2004; van der Hoeven and Lübker, 2006; Ball et al., 2013). In an example of a different kind, in 2012 a fire killed more than a hundred workers in a garment factory in Bangladesh – not an uncommon event in that country. It subsequently emerged that global retailer Wal-Mart, one of the factory's major customers, had resisted initiatives to improve worker safety because of their cost (Greenhouse, 2012). Wal-Mart was distinctively able to do this because of the market power it exercises over suppliers through commodity chains that cross multiple national borders.

Against this background the international human rights framework, described by a former United Nations High Commissioner for Human Rights as 'the closest thing we have to a shared values system for the world' (Robinson, 2007), can serve as a valuable resource for reducing health inequities that result from the operation of the global marketplace (Schrecker et al., 2010). Historical sociologist Margaret Somers (2008), in fact, points out that human rights challenge much current economic wisdom by insisting on people's 'right to have rights' independent of what they can buy or sell in the marketplace. Most of the world's countries, the USA being the most conspicuous exception, have ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR), a basic treaty that sets out 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (subsequently referred to for convenience as the right to health) and to 'an adequate standard of living ... including adequate food, clothing and housing' (United

Nations, 1966, Articles 11, 12). Ratification means that states have a three-fold responsibility to respect, protect and fulfil the rights set out in the relevant treaty (Maastricht Conference, 1998). In 2000, the United Nations' Committee on Economic, Social and Cultural Rights (2000; see Box 1) set out an expansive interpretation of the right to health that includes both health care and 'the underlying determinants of health' such as food, access to water and sanitation, housing, and healthy occupational and environmental conditions.

This view of states' obligations stands in dramatic contrast to much contemporary economic policy wisdom. In the words of *The Lancet* Commission, 'the power of the market often supersedes the power of human rights norms, including the right to health'. As in most other areas of international law, no supranational mechanism exists to enforce human rights norms or, for example, 'to mediate between the normative orientation of the WTO [World Trade Organization], where the primary objectives are trade liberalisation and little state intervention, and the UN human rights system' (Ottersen et al., 2014). Despite much talk about a post-Westphalian order, national governments bear primary responsibility for human rights, and realising even core human rights obligations related to health (see Box 1) requires, in the words of one noted human rights scholar, 'an activist, committed state party, with a carefully honed set of public policies related to the right to health' (Chapman, 2002). Such activism and commitment may hold little attraction for the privileged, and may be seen as an obstacle to such objectives as attracting investment from transnational corporations. The inability of those whose economic and social rights are most in need of protection to defend and advance those rights creates a major accountability gap (Yamin, 2009).

Many governments have incorporated some version of the right to health into their constitutions – probably the least ineffective form of implementation, as shown in the case of access to essential medicines (Hogerzeil, Samson, Casanovas and Rahmani-Ocora, 2006) – or legislation. Few have fulfilled the promise of 'shift[ing] the paradigm ... from the optional realm of *charity* to the mandatory realm of *law*' (Nygren-Krug, 2013) by recognising that rights-holders have a valid claim on resources needed to realise those rights. Indeed, making health-related rights enforceable through the courts has arguably led to mixed results (Cabrera and Ayala, 2013); marginalised and vulnerable groups may lack access to the legal process, and political executives and legislatures may simply ignore court decisions. Further, the world's wealthy and powerful states, which dominate the decision-making of

institutions like the International Monetary Fund (IMF) and World Bank, have at least until recently shown little inclination to integrate concern for health-related human rights into their policy positions (Hammonds and Ooms, 2004) or to ensure that the activities of transnational corporations headquartered within their borders are consistent with human rights norms.

It can be objected that many states lack the resources to make the right to health a reality. The concept of progressive realisation (see Box 1) takes this into account, yet at the same time ICESCR requires that human rights be given priority when scarce resources are allocated, and normally precludes measures that reverse previous progress (retrogression). It can be argued that resource scarcities in an absolute sense are less common than 'failures of political will that are cloaked in claims of resource scarcity' (Yamin, 2009). A strategy that has been described as interrogating scarcity (Schrecker, 2013) can be useful by contrasting situations in which resources are regarded as scarce with those where resources are treated as abundant, or opportunities to mobilise resources are neglected. For example, Drèze and Sen (2013) observe that a bill aimed at improving food security in India was described by critics as 'financially irresponsible' when its officially estimated annual cost was approximately half the revenue foregone each year by exempting imports of diamonds and gold from customs duties.

More generally, India is a country with a substantial middle class and an expanding stratum of the ultra-wealthy (Roy, 2012) in which access to sanitation is so poor that 'a full 50 per cent of households had to practise open defecation in 2011' (Drèze and Sen, 2013); under-nutrition is widespread; and access to health care is highly dependent on private spending (Drèze and Sen, 2013). Elsewhere, in 2001 the member states of the African Union (AU) committed themselves, without setting a target date, to increasing public spending on health to 15 per cent of their general government budgets. Twelve years later, although public spending on health had increased substantially, only a handful of states had met the target (AU, 2013). The fact that they included some of the continent's poorest countries suggests that lack of political will may be part of the explanation, as does the fact that in 2010 AU finance ministers urged abandonment of the health spending commitment (Njora, 2010).

The claim is not that most African countries can mobilise the resources needed for full realisation of the right to health. Clearly most cannot, hence the importance of external finance in the form of development assistance (Sachs, 2007) and of measures to combat debilitating levels of capital flight (Ndikumana and Boyce, 2011), which is rarely considered as a human rights issue. The point rather is a political one: in countries rich and poor alike protecting health, especially the health of the poor, is just one competitor among many for policy attention and resources, and often not one with strong domestic constituencies.

Similar observations about politics apply to the situation of wealthier countries in the aftermath of the financial crisis, as selective austerity programmes implemented in order to reduce government deficits have not only compromised access to health care but also multiplied the numbers of people whose livelihoods are precarious and insecure (Stuckler and Basu, 2013). Such programmes are often driven by the demands of external actors, like the IMF and (in the case of recent European events) the European Central Bank. The speed with which literally trillions of

## Box 1 Rights framework

### Key institutions and concepts

**General comments:** Interpretations of the obligations of governments that have ratified the ICESCR, issued by the United Nations' Committee on Economic, Social and Cultural Rights, one of ten 'treaty bodies' that monitor implementation of the major international human rights treaties. General Comment 14 explicates the content of the right to health.

**Progressive realisation:** ICESCR requires each state that has ratified the agreement 'to take steps ... to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant' (Article 2.1). This principle was interpreted in one of the first General Comments as 'recognition of the fact that full realisation of all economic, social and cultural rights will generally not be able to be achieved in a short period of time'. However, states have an 'obligation to move as expeditiously and effectively as possible towards' the full realisation of economic, social and cultural rights (Committee on Economic, Social and Cultural Rights, 1990).

**Non-retrogression:** Furthermore, 'any deliberately retrogressive measures in that regard would require the most careful consideration and would need to be fully justified by reference to the totality of the rights provided for in the Covenant and in the context of the full use of the maximum available resources' (Committee, 1990). General Comment 14 makes a similar observation with specific reference to health.

**Minimum core obligations:** The most basic requirements related to economic, social and cultural rights. According to General Comment 14 'a state party [a state that has ratified a treaty] cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations ... which are non-derogable' (Committee, 2000). In the case of the right to health these include the right of access to health facilities on a non-discriminatory basis; to the minimum essential food; to basic shelter, housing, sanitation and potable water; and to essential drugs. Governments are also obligated to 'adopt and implement a national public health strategy and plan of action' using a 'participatory and transparent process', and to monitor its implementation.

### Thematic mandate holders (Special Rapporteurs):

Individual experts (known as Special Rapporteurs) or, less frequently, working groups appointed by the President of the United Nations Human Rights Council (which replaced the Commission on Human Rights in 2006) to inquire into the realisation of specific human rights. There are currently Special Rapporteurs on the right to health, and also on health-related economic and social rights including housing, education, and food and on extreme poverty. Their reports are often hard-hitting – a report on the United Kingdom's housing policy aroused considerable controversy at the end of 2013 (Rolnik, 2013; Gentleman and Butler, 2014) – but are not backed up by any formal or informal sanctioning process.



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### Partnership for health

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dollars were mobilised to rescue financial institutions suggests that resources were, and are, not scarce in an absolute sense. The impact on economic and social rights was clearly retrogressive; a report by the United Nations' High Commissioner for Human Rights argues that austerity measures with such impacts must be defended in six respects: the existence of a compelling state interest; the necessity, reasonableness, temporariness and proportionality of the austerity measures; exhaustion of alternative and less restrictive measures; non-discrimination; protection of a minimum core content of economic and social rights; and genuine participation of those affected (Pillay, 2013).

If mechanisms existed to hold governments and international institutions to these standards, today's economic and social policy landscape in much of the world would look quite different. *The Lancet* Commission argued for seeking 'improved recognition of health as a human right' using a variety of mechanisms, including a strengthened mandate for Special Rapporteurs (see Box 1) that includes 'human rights audit of the decision-making processes of international organisations' (p. 660).

As important as they would be, such measures represent first steps. At the level of domestic policy, taking human rights seriously would preclude many economic policies and development strategies in which policies that inflict short-term pain on vulnerable populations are justified by anticipation (whether realistic or not) of long-term gains. And an effective multilateral framework for human rights accountability might, for example, constrain governments' domestic and foreign policy choices to the same degree as contemporary trade agreements, and create an exemption from trade sanctions if governments could defend an otherwise impermissible trade-related policy with reference to their human rights obligations.

In all this it must be emphasised that human rights, including but of course not only the right to health, are not just aspirational. Despite today's deficiencies of implementation, they are established elements of international law that provide crucial foundations for building a more equitable world in the context of the post-2015 development agenda.

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