EDITORIAL

HEALTH AND HUMAN RIGHTS

Against the imperative to design and constantly redesign health systems to cater for human needs lie the deeper questions that underscore the role of health in helping to attain fundamental rights of humankind. Rarely, however, is health conceived as a pioneer in this context, the health sector being most often content to react to initiatives originated by the political arena, particularly by non-government organizations or individuals.

Yet arguably, health itself is a basic human right and at the same time it can act as the translator of other human rights. In an ideal world all people should have equal access to the same quality of health care regardless of socio-economic status; in a sadly realistic world the question of equity tends to become buried in rhetoric. Rich nations and poor nations offer widely differing levels of health care, the rich and poor within individual nations similarly have access to grossly divergent quality of services. The role of the private sector is the subject of much debate, but alongside the words the juggernaut rolls on faster and faster, even in some of the poorest of nations: health care for those who can pay the most. The profit motive has become the engine of growth as in the whole spectrum of the market economy: health is an industry like any other.

Against that somewhat pessimistic view is the enshrinement in the constitution of the World Health Organization in 1946 of *enjoyment of the highest attainable standard of health...as a fundamental right.* However, such phraseology does not necessarily convey power to enforce such as ideal, indeed international law has very limited power of enforcement in each nation (Leary, 1994). The extent to which national laws guarantee the right to health is highly variable; their application tends to be very closely tied to economic policies in each case rather than to fundamental obligations of society or of government.

What is very interesting, however, is the observation that economic resources alone do not necessarily bear any direct relationship with access to health care or with quality of that care. Thus Sri Lanka is a low income country with a life expectancy of 71 years, while China has a life expectancy of 69 years, in the same range as some high income countries. While these two cases require detailed analysis to fathom the underlying reasons, even superficially it is evident that social policies have placed health very high on the list of priorities and societal structure has permitted the enforcement of these priorities. The one country is small, compact, with a relatively high educational standard, the other is vast in population and geographical size, with less pervasive educational attainments but a functional socio-political network that has operated with meticulous attention to detail and to involvement of local political leadership in health education. There are clearly many roads to equitable health care distribution.

The other side is the question of whether health contributes to economic growth. The World Development Report (1993) concluded that *improved health contributes to economic growth in four ways: it reduces production losses caused by worker illness: it permits the use of natural resources that had been totally or nearly inaccessible because of disease: it increases enrollment of children in school and makes them better able to learn; and it frees for alternative uses resources that would otherwise have to be spent on treating illness.* It has not always been easy, however, to document these contributions in specific terms, so that financial planners have tended to ignore or downplay them and consider health as a burden to be tolerated rather than a net contributor to improved economic performance.

Merely to increase incomes does not guarantee improved health. Indeed, industrialization underlying most rich countries' wealth has in general led to the substitution of new diseases to replace old ones. Urbanization and the crowding it engenders brings another set of challenges to health and to equity: shanty towns are spawned, the poor workers who underpin economic growth still bear much of the disease burden, just a different spectrum than they bore in the rural areas from which they migrated. If we look at economic performance, United States has one of the most cost ineffective health systems while being the industrial leader in high tech development, whereas, as already noted,

China, while now expanding its industrial base rapidly, has had for a long time one of the most cost effective health systems (World Development Report, 1993).

These issues constitute only one aspect of human rights in relation to health. The industrial scene itself brings massive challenges in this context, with working conditions to the fore in relation to the potential for disease moderation. Environmental mismanagement brings other challenges in relation to disease patterns. Political harassment leads in many cases to direct threats to life, certainly to enjoyment of a healthy life, sometimes by nations purporting to be paragons of social virtue (Chomsky, 1994).

The spectrum of issues concerning human rights and health is a very broad one. It is thus of considerable interrest that a new journal, *Health and Human Rights,* has recently been established to focus on this spectrum, in an attempt to concentrate attention on the challenges for change. The first issue in the Fall of 1994 opens with a series of astringent articles, one of which challenges the true virtue of the 1993 World Development Report itself, a document that supposedly signalled the World Bank's newly proclaimed higher profile interest in the health sector. Thus Klouda (1994) praises the analysis in the Report but berates the prescription, which contains many of the elements that underscore the profit motive and the ineffective conceptual approach to health care of some rich nations. We welcome this new venture as a timely symbol of challenge and change and hope it will help to stimulate debate and action in this critical of the global health equation.

Unless the health care professionals, the health care administrators and the health systems planners are willing to place human rights at the top of their agendas, the issue will be taken from their grasp. Indeed, it may well be that analysis of the more effective and cost-effective health care national records will show that much of the relative success has come from outside the health sector itself. The latter might do well to give more attention to the vast range of factors outside the health sector as currently defined that impinge of the right to equitable health care and take up some of the leadership redressing infringements on human rights in the wider sense.

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