CHAPTER 2

Rights-Based Approaches to Public Health Systems

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INTRODUCTION

A rights-based approach to public health systems focuses on underlying determinants of health – the economic, political, and social systems that determine health status and have far greater impact on health than the provision of medicine. With an understanding that health vulnerability is societally structured, public health systems can be seen to protect and promote the health of entire societies, employing multidisciplinary interventions to address the underlying causes of health and disease. By employing the language of human rights in health-related issues such as equity, discrimination, and social marginalization, public health advocates can achieve tangible health policy gains. However, it is necessary that public health scholars first gain a deeper understanding of the language of human rights and how these legal obligations can be applied in alleviating underlying determinants of health at the societal level through public health systems.

International human rights offer a powerful policy discourse to address underlying determinants of health through public health systems, creating government obligations to fulfill the "conditions in which people can be healthy" (Institute of Medicine, 1988, p. 7). By framing health disparities as a "rights violation," public health advocates benefit from international legal standards by which to frame government responsibilities and evaluate

government policies, shifting the analysis of health reform from quality of care to social justice (Parmet, 2009). Applying the legal language of human rights to health policy debates, public health advocates can create a rights-based approach to disease prevention and health promotion through population-based public health systems (Hunt & Backman, 2009).

This chapter reviews the terms of the human rights debate, assesses the evolution of human rights for the public's health, and applies the normative frameworks of the right to health to reform the public health systems necessary to address underlying determinants of health through national and global health policy.

EVOLUTION OF HUMAN RIGHTS TO ADDRESS UNDERLYING DETERMINANTS OF HEALTH

Health rights have evolved to meet societal threats to health. If the right to health is to be viewed as historically situated and subject to normative evolution, it is important to understand the circumstances that have led policymakers to embrace changing conceptions of health in international law. Through advances in health threats, theories, and technologies, the means to achieve health have changed in fundamental ways not envisioned by the original framers of the right to health. At the population level, the field of public health, an outgrowth of the U.S. public health campaigns of the early part of the 20th century, has taken on international importance in health policy debates.

Reflecting this changing health landscape, international legal frameworks under a right to health have evolved from a right to medical interventions to a right to all those underlying conditions that structure health, including such disparate underlying determinants of health as resource distribution, gender, violence and armed conflict, and other "socially related concerns." This part chronicles the policy dynamics of the right to health at three seminal moments in its history, including (a) the expansive aspirational language of the 1948 Universal Declaration of Human Rights (UDHR), (b) the weakened legal obligations of the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR), and (c) the reclaimed public health standards of the 1978 Declaration of Alma-Ata, which would be codified by the United Nations in 2000 to address underlying determinants of health in General Comment 14 to the ICESCR.

With the United Nations seeking to rebuild a world ravaged by war and to address the deprivations that occurred during the Depression and War that followed, the 1948 UDHR includes a right to health that moves beyond

medical care, providing for a right to "*a standard of living adequate for the health* [italics added] and well-being of himself and of his family, including food, clothing, housing and *medical care* [italics added] and necessary social services" (UDHR, 1948, art. 25). In preparing this right to a standard of living adequate for health, derived from drafts of the American Law Institute, there was widespread international agreement that the human right to health included both the fulfillment of medical care and the realization of underlying determinants of health – including within this right public health regulations for food safety and nutrition, sanitary housing, disease prevention, and comprehensive social security (Eide, 1993). In operating through public health systems, it was clear that government responsibility for the attainment of health included obligations to provide the security and material environment necessary for the fulfillment of healthy conditions.

But with states subsequently avoiding the right to health at the height of the Cold War, the United Nations General Assembly summarily weakened proposals for a right to health in the 1966 ICESCR, eliminating the definition of complete health and reference to "social well-being" from the right and replacing it with the ambiguous "highest attainable standard of health" (ICESCR, 1966, art. 12). Furthering this ambiguity in the content of the right, the General Assembly removed from the right any specific mention of underlying determinants of health—nutrition, housing, sanitation, recreation, economic and working conditions—leaving in its place the vagueness of government responsibility for "environmental and industrial hygiene" (ICESCR, art. 12).

As ideas about health changed in the late 1960s, however, so too did support for human rights to address underlying determinants of health through public health systems. Although human rights discourses on health had veered away from a focus on public health and toward curative medicine during the post-War enthusiasm for scientific advancement, public health systems had showed far greater promise in preventing disease and promoting health, shifting public health discourse back toward underlying determinants of health through "primary health care" – that is, health care in addition to the underlying social, political, and economic determinants of health (Rosen, 1974). With health framed as a widespread social imperative rather than a limited medical challenge, human rights would be seen as instrumental to the realization of public health systems.

In 1978, as the ICESCR was coming into law, the World Health Organization (WHO) and the United Nations International Children's Emergency Fund (UNICEF) held an international conference to revitalize public health systems from a human rights perspective. This international conference, with representatives from 134 state governments, would adopt a Declaration

on Primary Health Care, a document that has come to be known as the Declaration of Alma-Ata (WHO, 1978). Returning to the rights-based emphasis on underlying determinants of health in the Constitution of the WHO, the Declaration of Alma-Ata began with the statement that:

> health—which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity—is a fundamental human right [that] requires the action of many other social and economic sectors in addition to the health sector. (WHO, 1978, pmbl.)

To address underlying determinants of health under the Declaration of Alma-Ata, representatives laid out seven specific governmental obligations for essential aspects of "primary health care," including such underlying determinants as education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and the provision of essential medicines (WHO, 1978). Although WHO's focus on underlying determinants of health would wane in the ensuing years, the United Nations would reengage human rights for the public's health as it became clear that the right to health necessitated a contemporary reinterpretation if it were to frame rights-based public health systems (Meier, 2010).

CURRENT RIGHTS-BASED FRAMEWORKS FOR PUBLIC HEALTH SYSTEMS

The United Nations Committee on Economic, Social and Cultural Rights (CESCR) has taken the lead in developing a modernized right to health commensurate with an understanding of public health systems. General Comment 14, promulgated by the CESCR in 2000, interpreted the ICESCR to find that the right to health:

> is not confined to the right to health care. On the contrary, the drafting history and the express wording of article 12.2 acknowledge that *the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health* [italics added], such as food and nutrition, housing, access to safe and potable water and adequate sanitation, *safe and healthy working conditions, and a healthy environment* [italics added]. (¶ 4)

Thus, the CESCR finds the right to health to be an inclusive right, not restricted to medical care and treatment, but encompassing a broader array of underlying factors that impact health. At a minimum, these underlying determinants of health include access to safe and potable water, adequate sanitation, adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, access to health-related education and information (including on sexual and reproductive health), and participation in health-related decision making at community, national, and international levels (CESCR, 2000).

The right to health, according to General Comment 14, entitles individuals "to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health" (CESCR, 2000, ¶ 8). In realizing this right, a state must consider four key measures when assessing its compliance across the facilities, goods, services, and programs that comprise its public health system:

- *Availability*—the state must ensure that a "sufficient quantity" exists of resources integral to health, including sanitation, safe and potable drinking water, functional health services, trained health care professionals, adequate treatment facilities, and access to essential medicines.
- *Accessibility*—the state must remove barriers to access to health facilities, goods, and services, whether these barriers are imposed through economic, geographic, physical, or informational means.
- *Acceptability*—the state's health facilities, goods, and services must be satisfactory, according to cultural traditions and standards of medical ethics.
- *Quality*—the state's health facilities, goods, and services must maintain a level of quality consistent with medical and scientific standards (CESCR, 2000).

In meeting the substance of these commitments under the right to health, states assume three types of obligations:

- *Respect*—avoid interference with the right to health through its actions or omissions
- *Protect*—constrain the actions of third parties that may undermine the right to health.
- *Fulfill*—take affirmative steps to achieve the right to health (CESCR, 2000).

Through these overlapping frameworks, General Comment 14 recognizes the interconnectedness of governmental and nongovernmental actors in creating a robust public health system that can adequately support the necessary range of economic, political, and social determinants of health. To carry out these obligations, states must adopt a "national strategy" to realize the right to health and support a public health system that adequately maintains underlying determinants of health. Furthering this strategy, states must promulgate the necessarily legal infrastructure to support these measures and develop an implementation plan with appropriate "transparency" and "accountability" (CESCR, 2000, ¶¶ 53–56).

Although the right to health remains subject to "progressive realization"—affording states time to construct health systems in accordance with the "maximum available" national resources—General Comment 14 nevertheless imposes significant parameters on the application of the right to health through public health systems (Freedman, 2009). As states each develop national plans, benchmarks, and indicators, investigations have begun to determine whether measurable progress has been made toward realizing the right to health (Backman et al., 2008).

Further elucidating the content and application of General Comment 14, several analytical reports by the United Nations Special Rapporteur on the Enjoyment of the Highest Attainable Standard of Physical and Mental Health have examined the relationship of health systems to the right to health, recognizing that "a strong health system is an essential element of a healthy and equitable society" (UN Report of the Special Rapporteur, 2008, p. 12). Drawing on WHO's identification of six building blocks for a health system (health services; health workforce; health information systems; medical products, vaccines, and technology; health financing; and leadership, governance, and stewardship [WHO, 2007]), the Special Rapporteur has analyzed the interface between these building blocks and the right to health, concluding with a series of legal reforms to strengthen public health systems through national health policy (UN Report of the Special Rapporteur, 2008).

APPLICATION OF A RIGHTS-BASED APPROACH TO PUBLIC HEALTH SYSTEM REFORM

In examining the national experience, it has become clear that a rights-based approach to public health system development and reform means much more than simply ratifying international treaties. To address the multiple levels between the international human right to health and

national public health system reform, this part aims to clarify through comparative case studies the evidence for rights-based approaches to advancing public health systems and to outline through international legal standards the basis for rights-based health reform in the United States. (A more extended discussion of a rights-based approach to U.S. health care reform is discussed in chapter 4.)

Comparative Analysis of Rights-Based Health System Reforms

Analyzing these data across rights-based health system reforms, three themes emerge: (a) the place of social determinants within a rights-based approach; (b) equity as an explicit goal of a rights-based public health system; and (c) how a human rights approach addresses vulnerability.

Social Determinants of Health and a Rights-Based Approach

Although General Comment 14 clearly recognizes that the right to health encompasses underlying determinants of health, taking direct account of socioeconomic determinants in a rights-based framework is not always explicit. For example, in the United Kingdom, recent policy concerns for reducing avoidable health inequalities have led to attempts to include selected social and economic factors within resource allocation formulae to take better account of the impacts of social determinants on health inequalities (Smith, 2008). However, such exploratory work is not recognized as asserting a rights-based agenda in the British context. Similarly, research with parliamentarians in Southern and Eastern Africa has illustrated that members of health portfolio committees frequently identified key socioeconomic determinants outside of the health sector—such as food security, social grants, and education (which are elements of the right to health)—as important challenges for their work, but did not identify them within a rights paradigm (London et al., 2009). Bringing the lens of discrete legal obligations to these determinants of health will help to sharpen state accountability in ways that have not yet emerged.

Equity as an Explicit Goal of a Rights-Based Public Health System

Unlike earlier conceptions of equity as one of several important but competing public health considerations for public health system reform, there is increasing recognition that health equity is, of itself, the critical goal of a rights-based system rather than a goal instrumental to the achievement of a public good (Evans et al., 2001). The WHO Commission on Social

Determinants of Health (2008) has provided much of the evidence that inequalities in income, social situation, and power are the key obstacles to reducing health inequalities and are more important than investments in health care alone, finding that health systems that make equity an explicit goal are more likely to achieve overall reductions in morbidity and mortality. As seen under the Brazilian Unified Health System (Sistema Único de Saúde), an equity-based system can offer new ways of working at the primary health care level and establishing new forms of accountability, successfully reducing mortality and morbidity (Cornwall & Shankland, 2008). Under counterfactual conditions—where neoliberal health care reforms subordinated equity to considerations of efficiency, requiring cutbacks in state expenditure and reductions of public services—ideologically driven decisions for public health systems have generally been profoundly negative in equity of coverage and access to services (De Vos et al., 2006). Despite the recent moderation of these detrimental health care reforms, human rights principles provide a sustained framework for moving toward equity in the creation of effective public health systems to address underlying determinants of health.

A Human Rights Approach and Vulnerability

Finally, because human rights are inherently focused on substantive equality, rights-based approaches would give preference to the needs of vulnerable groups. Complementing efforts to afford greater protections for vulnerable groups, a rights-based approach recognizes and strengthens the agency of vulnerable groups to take action to change the conditions of their vulnerability (London, 2007). The engagement by civil society actors with the state could help to advance rights-based programming through collective agency and engagement in public health policy reform (Yamin, 2000). Through such engagement, vulnerable groups would find a voice in the policy process, breaking with the idea of health service users as either passive recipients or as empowered clients, but rather as rights-holding citizens engaging with a state that is obligated to establish mechanisms for citizen participation.

U.S. Rights-Based Health System Reforms

Applying such rights-based approaches to health policy reform in the United States, public health systems can address underlying determinants of health—including gender, race, and age—through human rights frameworks to inform public health policies and improve health outcomes (Yamin, 2005). International human rights treaties, such as the

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Convention on the Elimination of All Forms of Racial Discrimination (CERD), and the Convention on the Rights of the Child (CRC), provide these frameworks to establish rights-based policies for U.S. public health system reform.

To address gender as an underlying determinant of health, systemic reform efforts must combat gender inequality and discrimination. Rights-based U.S. health care reform strategists thus incorporate human rights norms enumerated in the CEDAW and its interpretive documents. The CEDAW establishes a state obligation to take "all appropriate measures, including legislation, to ensure the full development and advancement of women, . . . human rights and fundamental freedoms on a basis of equality with men" (CEDAW, 1979, art. 3). Despite U.S. reluctance to ratify the CEDAW, local NGOs and governments have applied rights-based frameworks to improve women's health outcomes, including a San Francisco ordinance based on CEDAW principles, which resulted in the dramatic expansion of intervention and prevention services to women-survivors of intimate partner violence and sexual assault (Murase, 2005).

Similarly, to address race as an underlying determinant of health, the CERD enumerates legally binding obligations to employ a rights-based framework for combating racial inequity in health. Indeed, CERD obligates the U.S. government to take affirmative steps to:

> eliminate racial discrimination in all its forms and to guarantee the right of everyone . . . to equality before the law, notably in the enjoyment of . . . the rights to public health, medical care, social security and social services. (CERD, 1966, art. 5)

Rights-based health system reform efforts must work toward eliminating racial discrimination at structural and programmatic levels as well as racial disparities in health outcomes. As an example of attempts to do so, NGOs have evaluated the reproductive health of minority women in the United States in light of government obligations under the CERD, focusing on issues of maternal mortality, sexually transmissible infections and unintended pregnancies where women of color are adversely affected (Center for Reproductive Rights, 2007).

Finally, to address age as an underlying determinant of health, the CRC offers a human rights framework to formulate rights-based approaches for the improvement of children's health. Human rights norms prioritize the protection of children, the provision of child health services, and children's participation in improving their health outcomes (Waterston & Goldhagen, 2007). To that end, the CRC specifically focuses on state

obligations to diminish infant and child mortality, develop primary health care, combat disease and malnutrition, ensure appropriate prenatal and postnatal health education and care for mothers, and develop preventive health care, guidance for parents, and family planning education and services (CRC, 1989).

Although the United States has not ratified the CRC, strategists such as the Campaign for U.S. Ratification of the Convention on the Rights of the Child have incorporated its norms into domestic health care reform efforts by advocating for public health systems to address issues of child survival, development, protection, and participation (Todres, Wocjik, & Revaz, 2006). Following the lead of other state and local governments, the city of Chicago has incorporated the CRC's norms in a resolution to "advance policies and practices that are in harmony with the principles of the Convention on the Rights of the Child in all city agencies and organizations that address issues directly affecting the City's children" (Campaign for a New Domestic Human Rights Agenda, 2009).

CONCLUSION

Framing health inequities as a "rights violation" offers international standards by which to frame government responsibilities and evaluate conduct. By applying human rights standards as a substantive and decision-making framework, human rights can be applied to create a rights-based approach to underlying determinants of health through public health systems.

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