Health and Human Rights: The Equity Issue

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I confess to some trepidation about entering a discussion on human rights and particularly in relation to health, as I sometimes have had a vigorous reaction to my perspectives on some of the common current notions. I grew up with the conviction that the Universal Declaration of Human Rights was a credo that could guide my own actions. I considered the basic human rights to be those of life, liberty, and the security of person.

Later, I came to be concerned when I saw the proliferation of needs and attributes that were also said to be basic or fundamental human rights. I often took comfort in the words of the American Declaration of the Rights and Duties of Man, which, in relation to health, affirmed:

> Every person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care to the extent permitted by public and community resources.

Of course, had I been a participant in the drafting process I would have insisted that the declaration be gender neutral and include promotion as well as preservation. Nevertheless, this is very much in line with the Universal Declaration, which did not speak of a right to health, but of the right to a standard of living adequate for health and well-being. I also note with pleasure the Declaration of the United Nations Conference on Human Rights (Vienna, 1993), which said, *inter alia*, that all human rights derive from the dignity and worth inherent in the human person.

I recognize that many of these words and phrases are not contextually empty. It is more than provision for an exercise

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in wordplay to have a forum where those interested in health can discuss their concerns and practices in relation to human rights. When I became Director of the Pan American Health Organization (PAHO), I made it clear that two basic principles would guide our work and be an indication of our most important core values. These two principles were equity and PanAmericanism. The former can give rise to many intricate interpretations, but I regard it simply as a search for fairness and often remind my colleagues of Aristotle's dictum that the essence of inequality is to treat in an equal manner those that are unequal. The latter represents our firm conviction that the countries of the Americas can advance more rapidly in health if they genuinely work together—PAHO was established to facilitate this joint work.

Thus, I tend to see many, if not most, major health problems through these lenses, and I would posit that the major global challenges exist as problems in large part because of the inequity that exists between and within countries. My opinion is, of course, colored by my experience in the Americas.

New and emerging diseases must be of concern to us all. The U.S. Centers for Disease Control and Prevention stated that in the last 20 years some 50 diseases that are new or were once thought passé, have come to haunt us. When one looks at the factors that have caused this phenomenon, one is struck not only by the changes in the microbes themselves, but by the environmental degradation, the alterations in human behavior, and the demographic changes that have occurred. These changes are intimately linked with the inequalities of opportunity that, for example, cause massive urbanization, the creation of large slums, and large populations of the depressed and deprived.

It is common to attribute these differences among people to the vagaries of economic opportunity. In PAHO, we view this more widely and speak only of health and economic growth as two key components of human development. Inequity in the economic sphere is well documented, and we take no pride in the fact that the Americas is the region with the greatest disparity in income distribution. It is absolute poverty as well as unequal distribution of wealth that con-

tribute to the situations which serve as incubators for many of the new or re-emerging diseases.

We know better the situation with respect to children and their health. The differences in child mortality between rich and poor countries is common knowledge. It is equally shocking to note the differences within countries. In the capital city of one of our countries, the infant mortality rate is about 50 per one thousand live births, while in some of the rural areas it might be three times higher.

What does PAHO do to address these basic problems of inequity, or rather how do we help our countries to search for the equity that I believe is related to securing human rights? First, after having indicated the vision we have of an organization working towards securing equity, we articulate a mission that identifies what we will do. The essence of that mission is our commitment to technical cooperation with countries and stimulating cooperation among them in the spirit of PanAmericanism.

Then we ensured that our structure responds to the need to seek equity through specific program areas. Our governing bodies identified five areas that are referred to as our Strategic and Programmatic Orientations. I will only mention two of these areas and the technical divisions that cover them as illustrations. One is Health and Human Development. A great part of technical cooperation in this division is directed toward demonstrating the validity of our thesis that health is an integral part of human development, and to this end we have structured a deliberate approach to a wide array of resources. Among the most important are political resources, and we have systematically sought and received access to presidents, prime ministers, and their cabinets in order to present the notion of health as an equity issue, not simply a care issue, at the heart of their efforts for national development. We have established firm contacts with the parliaments of the region and with their commissions on health to articulate the same message.

But it is not enough to speak of inequity; we have to be able to show where it exists and to have the data to demonstrate what interventions are effective. Therefore, we have a vigorous program to assist countries in generating reliable data and analyzing it. We will soon have basic core data on

health from every country in the Americas available to everyone in the hemisphere. We also publish fact sheets on basic indicators on health and health-related areas. I am convinced that one of our responsibilities is to monitor the human condition. When rights are breached and the result is health damage, our call for correction must be based on data.

One of the components in this division of which we are most proud is the Program on Women, Health and Development. This program concentrates on those health conditions that are a manifestation of gender inequity. It is an uphill struggle to have the health establishment recognize the needs of women as women and the subtle but real gender discrimination that exists, for example, in our health services. We are not short of examples of events and actions that run contrary to the affirmation of the dignity and worth inherent in the human person when such a person is female.

One of the other divisions in PAHO is concerned with the organization of health systems and services. Recently, the main focus of its work has been on assisting countries with their health sector reforms. Some 28 of our member states are undertaking some type of health sector reform, with the major goal being equity in the provision of services. We know, for example, that whereas in the richest of our countries almost 100 percent of women have prenatal care, in the poorest ones this figure is about 60 percent. As would be expected from these data, almost 100 percent of births in the rich countries are attended by trained personnel while for the poorest this figure is about 40 percent.

Certain approaches to reform are common in the countries. There is a universal acceptance of the need for decentralization, the establishing or expanding health insurance, the adoption of some basic package of health services, and ensuring that the state retain responsibilities for what might be called the traditional public health services. We still continue to press for application of the primary health care strategy and are helping our countries in practical ways to renew their enthusiasm for Health For All, which is essentially an equity issue. We no longer beat the drum to shift resources to the primary care level but concentrate more on making the other areas so efficient that there are indeed resources available for primary care.

Finally, I must mention one program that relates to children and perhaps also to their rights. PAHO is proud of its Special Program on Vaccines and Immunization. It is now common knowledge that five years have elapsed since there was paralytic poliomyelitis in the Americas, and measles is disappearing fast. In the last four years, not a single case of measles has been confirmed from the Caribbean, and in the last year, there was no importation of measles into the United States from Latin America. This means that our countries have been successful in immunizing their children. These children enjoy the right as expressed in the American Declaration, to "specific sanitary and social measures,"certainly as related to one aspect of their health care. There is no inequity as far as immunization is concerned. The success of the effort has been a marvelous tribute to the PanAmerican approach.

One is tempted to ask why there are so many manifestations of inequity in other areas of child health and why the right to access to sanitary measures is not universally observed and practiced. I am not satisfied with the simplistic answer that it is because of the uneven distribution of technology. Perhaps solutions in some of these fields will only be found when recognition of the underlying inequity is raised to a moral and ethical issue in the Aristotelian context of personal morality and the ends of human life.

You will have perceived, quite properly, that our focus as a public health agency—one that is primarily concerned with the health of the public—is the health of population groups. But I always insist that we must never lose sight of individual concern and need, because pain, illness, and death are individual events. Similarly, my major orientation is toward preventing the deprivation of rights of groups that finds expression in disturbances in the public's health while retaining consciousness of individual rights. But indeed, deprivation of any rights is a manifestation of the creation of a class of *others*, and deprivation is heinous particularly when comparison is made with those who are not affected or deprived. If there were no deprivation, there would be no *otherness*. I translate this into health and shape it in terms of equity or inequity, and I hope I have shown in this presentation some of the ways we are seeking to reduce inequity of rights.

I pursue this course for moral, ethical, and very practical reasons—and I might add, a philosophical reason. I have said that health and reduction of inequities just might be the kind of noble cause to which nations of the world might address themselves now that many of the other reasons for divisive struggle in a global world are past. And as I thought of that exciting possibility, in the words of the old song, "I said to myself, what a wonderful world!"

Suggested Readings

R.G. Wilkinson, *Unhealthy Societies—The Affliction of Inequality* (London and New York: Routledge, 1996).

Pan American Health Organization,"The Search for Equity," Annual Report of the Director, 1995.

H.L. Fuenzalida and S. Scholle-Connor, "The Right to Health in the Americas: A Comparative Constitutional Study," Pan American Health Organization, 1989.