Hauora - Everyone's Right

Keeping up to date

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Health promotion, human rights and equity

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Introduction

Throughout New Zealand, and the rest of the world, people attain very different standards of health. Consistently, across and within all countries, poor people experience worse health than those on middle incomes who in turn experience worse health than those who are best off. This inequity in health is not a result of natural causes. It is, as described by the World Health Organization's (WHO) Commission on the Social Determinants of Health (CSDH), the result of a "toxic combination of poor social policies and programmes, unfair economic arrangements and bad politics" (World Health Organization, 2008, p. 1).

Keeping up to date - Edition 35

Welcome!

Each issue tells you about a current research, evidence and thought on an important issue for your work in health promotion. All articles are peer reviewed.

This edition is on health promotion, human rights and equity.

We are thankful to Carmel Williams, the author of the article. We also acknowledge the reviewers.

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In this issue of 'Keeping Up To Date' we look at the important and practical role of health and human rights in the health promotion armoury to redress these inequities, and not just by resorting to judicial processes. All people working in health promotion are working for the right to health!

Health inequity globally and locally

The differences in health and wellbeing across the social hierarchy, and between ethnic groups, are not innate or natural, and the circumstances causing these unfair differences can be changed. The work of health promotion aims to bring about these changes, by advocating for fair social policies, programmes, and economic arrangements. This involves addressing the unequal distribution of economic and social resources, so that those worse off in society achieve the same access to health care and education, and have conditions at home and work, that promote a life of dignity and opportunities to flourish.

In New Zealand Māori carry a greater burden of health inequalities and die about eight years earlier than their Pakeha cohort (Rochford & Signal, 2009). Pacific men and women have life expectancy at birth lower than the average for New Zealand: 4.3 years lower for men and 4.1 years lower for women, and in 2000 their avoidable death rate was 50 per cent greater than for the total New Zealand population (Tukuitonga, 2011).

There are also differences in health between people in different socioeconomic groups. New Zealand men on low incomes have twice the risk of premature death as men on high incomes, and the risk of death for children in low income households

Carmel Williams

is about twice that for those in high income households (Public Health Advisory Committee, 2004).

Hard economic times quickly have a worsening effect on the health of the poorest people in the community. In New Zealand, this has been shown in, for example, studies of life expectancy, and a range of measures of wellbeing. (Blaiklock et al., 2002; Tobias, Blakely, Matheson, Rasanathan, & Atkinson, 2009). Despite considerable evidence of the effects of the low priority given to children, as a recent editorial in the New Zealand Medical Journal noted, New Zealand continues to spend less than half the OECD average on young children. 'Childhood diseases related to poverty and crowded housing are still prevalent in New Zealand and are a national shame' (Sharpe, 2011).

Continued on page II

Looking beyond health to improve health

It can be seen then that most differences in health experienced across a society arise from factors beyond health care itself: the determinants of health. For example in 2004, the Public Health Advisory Committee stressed the urgent need to increase the availability of good quality affordable housing, education, employment opportunities, good childcare, and income support for those who are unable to work, to improve health.

Recently the New Zealand Medical Association released a position statement on health equity that called for action from local government, social development, transport, finance, education and justice(New Zealand Medical Association, 2011).

A role of health promotion is to shine a light on the impact of all policy and practice on health, and use these findings to shape future policy. In human rights terms, this role is termed "constructive accountability".

In the next section, before looking at the specifics of the right to health we will examine the Treaty of Waitangi, and the Declaration on the Rights of Indigenous Peoples. Both these documents are of great significance for health promotion and addressing the conditions that have led to the inequity in the attainment of health in New Zealand.

Te Tiriti O Waitangi, Indigenous rights, and the right to health

All human rights treaties are premised on the dignity of all human life and carry significant non-discrimination clauses. Te Tiriti O Waitangi similarly addresses human rights in all four articles. However, it is usually considered that the non-discrimination clauses in the first international human rights treaties were not sufficient to secure a full realisation of rights (Toki, 2011). This has given rise to additional treaties and declarations, for indigenous people, women, people with disabilities, and children *(See Box 1)*.

Concerns have also been expressed among Māori that international rights covenants have emphasised the individual over the collective. A Māori perspective takes the view, as expressed in a report to the UN Committee on the Rights of Children in 2003, that for Māori whānau, balanced development ensures all whānau members develop together (Action for Children and Youth Aotearoa, 2003).

Box 1: Key human rights documents recognizing the right to health

New Zealand has ratified the following international treaties that recognize the right to health:

- International Convention on Economic, Social and Cultural Rights (ICESCR), NZ acceded in 1968, ratified 1978
- International Convention on the Elimination of all Forms of Racial Discrimination (ICERD), NZ acceded in 1966, ratified 1972
- International Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), NZ acceded in 1980, ratified 1985
- International Convention on the Rights of the Child (CROC), NZ acceded in 1990, ratified 1993
- International Convention on the Rights of Persons with Disabilities (CRPD) , NZ acceded in 2007, ratified 2008
- United Nations Declaration on the Rights of Indigenous Peoples, 2010

Guiding rights-based documents for health promotion:

- *Constitution of the World Health Organization, 1946*
- *Alma-Ata Declaration on Primary Health Care, 1978*
- *Bangkok Charter for Health Promotion in a Globalized World (2005)*

There are individual and collective rights and on occasion an individual right is restricted for public health purposes. Restriction of individual rights should never be undertaken lightly, but rather, as described by the Human Rights Commission, must be done in a balanced way. 'Where competing sets of rights intersect, one set does not simply override the other: they should be carefully balanced so as to maximise respect for all rights and rights-holders as far as possible. The Commission acknowledges that there is a perception that tensions exist between collective rights and individual rights. Human rights affirm the value of every single human life (right to dignity, right to equality, etc). However human rights cannot exist in the absence of a collective environment where rights are acknowledged and duties recognised' (Human Rights Commission, 2008).

In New Zealand, a person's freedom to smoke cigarettes anywhere has been restricted so that the health of non-smokers is respected and protected. The repeal of Section 59 of the Crimes Act restricted a parent's right to discipline their child as they saw fit when it involved physical force, to protect the rights of the child.

The UN Declaration on the Rights of Indigenous Peoples 2007, adopted by New Zealand in 2010, places cultural rights centrally, and declares that Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including in the areas of education, employment, housing, and health. Article 2 of Te Tiriti has implications for health and social policies, and includes the right of development. While the Declaration does not create 'new' rights, it is considered the only international treaty to view rights through an indigenous lens, and it also specifically recognises indigeneity.

This is well aligned with another crucial key human rights concept, applicable to all rights treaties: participation. Whether it is in policy and programme design, determining indicators, or measuring outcomes, people likely to be affected (stakeholders) must be active and equal participants in the processes.

Te Tiriti, and the Declaration, support, strengthen and promote Māori rights to health and social development, and importantly, enable a Māori perspective to be brought to the fulfilment of these rights.

In the next section, we look at the meaning of 'a right to health', to clarify the obligations of governments, and the entitlements of every person and, as viewed by Māori, their whānau, and community.

Using rights to strengthen health promotion

Over 60 years ago the nations of the world united in acknowledging in the Universal Declaration of Human Rights, the inherent freedom, dignity and equality of all people. Dignity and the freedom to live a flourishing life remain the central elements of all rights. The right to the highest attainable standard health pre-dated the Universal Declaration of Human Rights when it was articulated in the WHO Constitution in 1946. It has since been codified in numerous international and regional treaties, covenants and declarations, including the Alma Ata Declaration for primary health care, and the Bangkok Charter for Health Promotion, and is part of international human rights law. It is its legal standing that makes the right to health an exceptional tool for health promotion, bringing legitimacy and strength to strategies and advocacy.

The International Covenant on Economic, Social and Cultural Rights (ICESCR) set out, in 1966, the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. However, the obligations of governments under the ICESCR remained vague until the UN General Comment 14 was adopted by all members in 2000 (United Nations, 2000).

General Comment 14 clarifies the core obligations of the right to health, including primary health care, and the underlying determinants of health (potable water, sanitation, housing, adequate nutrition, and more), to which all people are entitled. The Comment proposes a framework for both process and accountability purposes. It states that health services and underlying determinants should be available, accessible, acceptable, and of good quality; it refers to key human rights concepts in the delivery of services, including participation, equality and non-discrimination, accountability and transparency. The Comment also defines violations of the right to health and means of redress.

The concept of progressive realization is important: where there is limited resource to meet all obligations immediately, it is acceptable to achieve them gradually. All countries must develop national health plans to demonstrate the progressive realization of the right to health, and must report on progress. It is not permissible to slide backwards against this plan, and the UN monitoring committees take any regression very seriously. For example, if a country's infant or maternal mortality rates worsen, such as in Papua New Guinea where maternal mortality appears to have doubled between 1996 and 2006, this requires urgent redress. The concept of non-discrimination holds even within progressive realization, so that it is not permissible to progressively realize one group's rights at the expense (regression) of another's.

The right to health is referred to in many other international covenants, and those that New Zealand has ratified are listed in Box 1. However, the precise duties to which these rights refer are most clearly defined in the ICESCR. In the following section, we examine their application to documented cases of health inequity.

Operationalising the right to health

Translation of the right to health into practice started in earnest in 2002, with New Zealand nominating the appointment of Professor Paul Hunt to be the first Special Rapporteur on the right to health. During his two terms, Hunt wrote over 30 reports to the UN on issues such as sexual and reproductive rights, access to medicines (including the duties of States and pharmaceutical companies), water and sanitation, maternal mortality, the skills drain, and health-related Millennium Development Goals.

All human rights, including the right to health, must be respected, protected and fulfilled *(see Box 2)*.This places an obligation on the government not just to fulfill health rights, but to ensure that actions taken by other parties do not interfere with people's health rights. Hunt's report on his mission to Peru illustrates this obligation. He examined and reported on the potential impact of the WTO-plus restrictions in a trade agreement between Peru and the US and warned that the provisions would significantly impede access to affordable essential medicines for some individuals and groups, including anti-retrovirals for people living with HIV/AIDS. This has relevance to New Zealand's trade negotiations providing a precedent whereby the health impacts of these talks should be examined. Whether it is in the export of unhealthy foods, or the promotion of privatization of health services, all our foreign policy and programmes would benefit from examination through a right-to-health lens.

The UN Special Rapporteur's mission to Peru also visited areas where environmental contamination from mining by foreign companies, and lack of access to clean water and sanitation, were having an acute impact on health. The report noted the severe impact on children and indigenous people, and stated that the Government had an obligation to respect the right to health, and to protect this right against harm by third parties. He also referred to rights conferred by the Convention on the Rights of the Child (United Nations, 2005).

His recommendations included the need for community participation in all decisions and planning that would involve their health or development; that independent rights-based environmental and social impact assessments are conducted prior to setting up all mining or industrial projects; that victims of health rights violations who had suffered harm should have access to effective judicial or other remedies at national and international levels, and receive adequate reparation; that the facilities leaking chemicals were urgently investigated and reasonable solutions considered, including closure or removal to different locations.

Compliance mechanisms

After ratification of a treaty, States are required to report every five years to a UN monitoring committee. The report covers general progress against the treaty, and against any recommendations made by the Committee, or Special Rapporteur, in previous reports.This process also accepts shadow reports from civil society, including national human rights organisations and those working in health promotion. This process enables human rights violations to be brought to the attention of the rest of the world, and it acts in a 'naming and shaming' manner on the international stage. Other mechanisms available to redress rights violations include human rights review tribunals and commissions, national judiciary systems and ombudsmen.

In New Zealand the Child Poverty Action Group took a case against the Government to the Human Rights Review Tribunal. It believed the In-Work Tax Credit was a discriminatory subsidy against parents who were on benefits.The initial finding, that the credit scheme is discriminatory but that the Government had proved this discrimination was justified, is being appealed and the case will be heard in September 2011.

Undertaking judicial procedures regarding violations of human rights is akin to putting the ambulance at the bottom of the cliff.

Continued on page IV

Box 2: Respecting, protecting and fulfilling human rights

There are three types of government obligations in human rights. Applied to the right to health these mean:

Respect the right, by refraining from stopping any person's enjoyment of the right to health. Therefore, governments must ensure policies and practices do not discriminate against any person on the basis of gender, ethnicity, age, poverty, location, resulting in restricting their access to health care, or to the underlying determinants of health.

Protect the right, by ensuring no third party or policy interferes with a person's enjoyment of the right to health.

Fulfil the right, by ensuring the right to health is enjoyed, and progressively realized. This includes ensuring health services and facilities, and the underlying determinants of health are available, accessible, acceptable and of good quality, to all people, including especially indigenous people and those in poverty.

And it may well be this element of the right to health that has stopped health workers from engaging with rights. Judicial processes are viewed as complex, inaccessible, expensive, and of little practical help in dealing with health crises on the ground. However, as elsewhere, rights concepts can be put to wider use in New Zealand.

Positive inputs to health

It is important to use human rights concepts, and service obligations, as a means of strengthening health promotion work and advocacy. This can be achieved by working with the key rights concepts, such as participation and non-discrimination, to keep progressively realizing the right to health as detailed in Ministry of Health national health plans. Examples in New Zealand include improved awareness of patients' rights following on from the Cartwright Enquiry into National Women's Hospital research in the 1980s; reducing the incidence of HIV has necessitated drawing on non-discrimination which is embedded in all rights including health rights; and changing Section 59 of the Crimes Act drew on the rights of children to be protected against violence.

Health promotion can use human rights concepts and practices in its own programmes as well as when examining all policies and programmes proposed by governments for their likely impact on people who are most disadvantaged in society. In practice, whenever new health programmes and policies are being developed (for delivery in New Zealand or overseas as part of our aid or foreign policy initiatives), these are the questions a rights-based analysis might ask:

- Were key rights concepts such as participation and non-discrimination an integral part of their development, with all parties being treated equally?
- Will this result in health services becoming more available, accessible, acceptable, and of good quality, for all and especially those most disadvantaged?
- Could this initiative have a negative impact on the health system and leave it less able to fulfil people's right to health?

Under international human rights law, policies that will harm health, and not promote the health of the poorest and Indigenous peoples, are a rights violation and the government should be advised of such, and encouraged to revise their policies. It is only if policies are not changed that evidence of retrogression in health rights will need to be collected and brought to the attention of the UN Monitoring Committees.

Applying a health rights lens in New Zealand

In New Zealand all policies and actions, whether GST on healthy foods, cessation of public health programmes, or general economic reforms, can be assessed through a right-to-health lens for their impact on health inequities. The Health Promotion Forum has adopted this perspective and reflects it in its vision, Hauora "everyone's right".

Research is an important tool to monitor health rights. Health indicators for all New Zealanders must continually improve, and when there is limited resource availability, international human rights law is clear that funding allocation must prioritise the indigenous and the most disadvantaged groups in society.

Speaking at the 20th IUHPE World Conferences on Health Promotion in Geneva 2010, Paul Hunt urged people in health promotion to use health rights to shape all policy and programmes so they are robust, sustainable, participatory, effective and meaningful to the disadvantaged. "It is an asset and an ally at the disposal of all of us committed to social justice" (Hunt, 2010).

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