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Introduction: Politics, Human Rights and Poor Global Health

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Can Campaigns to Prevent and Treat HIV and AIDS Revive and Strengthen Campaigns for the Right to Health, Access to Legal Services and Social Justice?

Introduction¹

Coming over the next few weeks:

- Chapter 1: Politics and the Global Public Health Crisis
- Chapter 2: Health and the Inequality of Poverty: Towards a Rights Based Convention on Global Health
- Chapter 3: South Africa's Treatment Action Campaign: An example of a successful human rights campaign for health?
- Chapter 4: Health and the Law: Using the law to Protect and Fulfill Human Rights; Using Human Rights to Health to Strengthen the Law
- Chapter 5: AIDS in the Time of Freedom: Law and Politics in the Response to South Africa's AIDS Crisis

In 1845, in his thesis on Feuerbach, Karl Marx wrote the now famous maxim that: "Philosophers have only interpreted the world, in various ways; the point is to change it."²

Over 160 years later, much the same criticism can be laid at the door of public health analysts. Prompted in large part by the HIV pandemic, the growing crisis of world health, particularly 'third world' health, and its social determinants has become a subject of an enormous amount of research and writing.⁴ or alcoholism. But in countries mired in poverty and inequality it causes disaster and death.

The avoidance of politics and political analysis in the plethora of analyses on health, in my view, sometimes leads to utopian constructions and arguments about how to improve health.

Indeed, to escape the problem of government and politics, a range of theories about 'governance' are being invented that dissipate state responsibility, and seek *a fortiori* to find theories that justify the shedding and shifting of governmental responsibilities in protecting or advancing health.

These theories often seize on the symptoms of the health crisis, rather than its causes. For example, what is the real significance of the alliance of bona fide but ad hoc organizations, measures and agreements (both at a national and international level) that have emerged which aim to promote or improve health?⁵ Are they part of a shift towards a necessary global governance ('outlines' that need to become 'pillars' in the words of David Fidler⁶) or are they a patchwork of institutions that have inserted themselves into the breach of governmental omission and operate from a range of different perspectives –humanitarian and political. Undoubtedly they are starting to ameliorate some of the symptoms of global ill health and bring relief to millions of people across the globe. But they simultaneously delay the need to address the underlying causes of the decay. And now, because so many lives are dependent on them, major questions must be asked both about their sustainability and unintended consequences.⁷

This paper does not reject these initiatives. They do contain the seeds of a new order of health. But I argue that if activists are going to change the course of global health, a more political approach to health advocacy is necessary.

My argument is that this model must be built in disadvantaged communities and target the nation state. It must be rooted in the active propagation of human rights and be assisted by more purposeful national and international legal frameworks on health and rights. Above all it must link health to the political struggles of poor people for

genuine democracy.

Various writers have pointed to the de facto globalization of health governance and from the academic literature about an international governance framework for health it would seem that all roads lead to support for the idea of a Framework Convention on Global Health (FCGH).⁸

A framework convention would therefore seal and codify a process that is already underway. But a framework convention, albeit vitally necessary, can be either an opportunity or a threat, it can begin to break the bad ways of conducting health or entrench them.

How, by who and on what principles a FCGH is constructed will decide this.

There are debates raging with different opinions about the relevance and efficacy of human rights based action and advocacy as one means of tackling both health inequality and governmental omission in investment and management of health. There is a justifiable scepticism about the anaemic models for human rights that have been advanced thus far, often academic and hard to apply to real life, and the failure of the international conventions on human rights to regulate governmental conduct.⁹

From the left there is a skepticism about human rights and particularly law as drivers for social change, both of which are viewed as liberal notions, spawned and re-legitimised by globalisation.¹⁰ But what is overlooked is how, inadvertently, globalisation may have given potential new power to human rights and agency to the poor people who use them. Combining political activism, legal action and human rights might be a new tool to 'govern governments' (in the word of Burris)¹¹ and insist on the right to health.

The following chapters admit that the efficacy and applicability of human rights will vary across countries. However, model health campaigns, in embryonic and, politically untheorised forms, have begun to take shape in a number of community-based responses to threats to health, including that of the Treatment Action Campaign (TAC) in South Africa.

To try to support the argument for using human rights as drivers of politics, in Chapter Three of this paper, I analyse some of the methods and achievements of the TAC. I try to provide the evidence that, under the pressure of a mobilized citizenry, states and private corporations, can be held accountable and cajoled, shamed or forced into meeting their positive duties around population health. However, while I argue that TAC offers a model that is applicable for social justice campaigns, I also assert that the TAC must itself evolve from being a grass roots movement that has primarily focused on HIV, to one that uses the same methods to campaign for the realization of the right to health and social justice more broadly.

This is necessary for several reasons: firstly to sustain the various achievements in increasing access to HIV treatment that TAC has catalysed thus far. Secondly, to lay the basis for a far-reaching change to the national and global equations of political power and priorities that, as one of their side-effects, decide the health of poor people.

Finally, I analyse one other issue that features in all of these discussions: the role and rule of law. But again, my take is a different one.

One of the features of governance internationally, post the end of Stalinism, has been the spread of the rule of law –sometimes deliberately fostered by organizations such as the World Bank, sometimes voluntarily embraced by people and governments wanting to protect themselves from arbitrary government and dictatorship. My argument is that a necessary component in the equation for health is for poor people to have progressively expanding access to the law, as a means to enforce human rights and in particular governmental duties. But by access to the law, I do not mean a theoretical constitutional right, but practical access beginning at a local level, but spreading to all areas of the legal system.

In this context I conclude this paper with an examination of the experience in South Africa, looking at what has been achieved by using the law, the inaccessibility of law to tackle inequalities, and what needs to be done to make it accessible. In particular, I argue that the South African constitution creates a similar duty on government to provide legal services as it does for health services – and that access to legal services is an essential part of democracy.

Finally, it is worth reminding ourselves that questions that are broached above are not academic or theoretical. On their answers and the actions that flow from them depend millions of lives.

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1. The author would like to acknowledge SANPAD for whose conference *The Poverty Challenge 2007: Poverty and Poverty Reduction in (South) Africa, India and Brazil*, chapter one and two of this paper was originally prepared for. I would also like to thank Atlantic Philanthropies for funding a sabbatical that made it possible to think more deeply about the issues it raises. Finally, thank you to Temple University which appointed me the Phyllis W. Beck Professor of Law in October/November 2007, where

much of what follows was eventually written.

2. K Marx, *Theses on Feuerbach*, 1845, Karl Marx and Fredrick Engels, *Selected Works in One Volume*, Lawrence and Wishart, 1968, p. 30.
3. See for example: Burris, Scott C. and Gostin, Lawrence O., *The Impact of HIV/AIDS on the Development of Public Health Law*. Also: *Dawning Answers: How The HIV/AIDS Epidemic Has Helped To Strengthen Public Health*, Ronald O. Valdiserri, ed., pp. 96-117, Oxford University Press, 2003 Available at SSRN: <http://ssrn.com/abstract=1022029>; O Aginam, *Global Health Governance, International Law and Public Health in A Divided World*, University of Toronto Press, 2005.
4. See, for example, Wyatt, S. et al. 2006. *Overweight and Obesity: Prevalence, Consequences, and Causes of a Growing Public Health Problem*. *American Journal of the Medical Sciences*. 331(4):166-174, April 2006.
5. For example the Global Fund to Fight AIDS, TB and Malaria (GFATM), The Bill and Melinda Gates Foundation, the Clinton Foundation, The International AIDS Vaccine Initiative (IAVI), etc.
6. D Fidler, *Constitutional Outlines of Public Health's New World Order*, 77 *Temple L. Rev.* 313 (2004).
7. J Cohen, *The New World of Global Health*, *Science*, Vol 311 Jan 2006, 162-167; L Garrett, *The Challenge of Global Health*, *Foreign Affairs*, Jan/Feb 2007.
8. Lawrence O. Gostin, Georgetown University, O'Neill Institute for National & Global Health Law Scholarship, Research Paper No. 1, *Meeting Basic Survival Needs of the World's Least Healthy People, Toward a Framework Convention on Global Health*.
9. An article by Sofia Gruskin (*Temple Law Review*, Vol 77 No 2, Summer 2004) exemplifies this. Although promisingly titled: *Is there a Government in the Cockpit: A Passenger's Perspective*, it fails to look at governments at all.
10. Krista Johnson for example makes the wish mother to the thought when she writes, without serious research or analysis that: "'human rights as an ideological and political initiative continues to be shaped within the hegemonic neoliberal framework that demands that we understand the AIDS pandemic as ... a health issue rather than as a development or human security issue, as an individual concern rather than as a community or global concern.'" See: *AIDS and the Politics of Rights in South Africa: A Contested Terrain*, *Human Rights Review*, Jan-March 2006.
11. S Burris, *Governance, Microgovernance and Health*, *ibid*, p 339 ("Non-state actors have taken on the role of governing, not just other private entities but the state itself.")

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Chapter One: Politics and the Global Public Health Crisis

By Mark Heywood

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“If you can have full employment by killing Germans, why can’t you have it by building hospitals?”

– Tony Benn, Labour Party MP, UK, referring to the move to set up a National Health Service in Britain after the end of World War II¹

Despite remarkable advances in modern medicine the health of millions of people throughout the world is declining.² Problems of malnutrition, maternal mortality and other causes of illness, disability and death persist on a huge scale. Underdeveloped and developing countries have become reservoirs for old and new pathogens, where communicable and largely preventable diseases, cause millions of deaths per annum.³ Thus, for example, the Global Alliance for Vaccines and Immunization (GAVI) records that 1.5 million children die per annum “in the world’s poorest regions from rotavirus and pneumococcal disease, diseases for which newly licensed vaccines are available.” It also points out that 28 million children “missed out on immunization during their first year of life - leaving them vulnerable to disease both in childhood and during the productive adult years.”⁴

At a national level, poverty and inequality, jointly and differently, fuel epidemics of the most locally established parasites, pathogens and viruses. In countries that are mired in poverty and economic stagnation, with little prospect of gaining ‘emerging market’ status, causes of ill-health are endemic, but more stable. By contrast disease is more active, epidemic and changeable in transitional economies such as Brazil, South Africa and China, where urban and peri-urban slums grow rapidly as people migrate away from rural areas in the hope of gaining access to jobs and services. In these countries there is often an almost complete absence of systems for infection control within and without health settings. There are periodic outbreaks of Cholera and Typhoid (in 2005, for example, there was a major typhoid outbreak in Delmas, an impoverished township less than 100km from Johannesburg).⁵ In addition there are periodic outbreaks of bacterial infection such as *Klebsiella pneumoniae*, (which caused the deaths of at least 21 children at a hospital in Durban in 2005) and other nosocomial infections.⁶

However, this rise in the prevalence of certain diseases has been matched with a declining capacity to manage it through public health systems.

In China, for example, the transition to a market economy is coming at a great cost to public health. Inequalities that are well-established in most African countries are now becoming the norm in China. For example, according to the WHO and World Bank, although China is ranked 61st out of 191 countries in health status, it is ranked 181st in terms of fairness of financial contributions to health; whilst 80% of total public spending on health is in urban areas, 70% of the population live in rural areas.⁷

At the 2007 Standing Committee of the National Congress of the People, China’s Health Minister admitted the massive growth in inequality and announced a major programme of investment in rural health services. However, the main reason for this seems not to be a reignited commitment to health, but fear of the growth in popular discontent about health services.⁸

Although the political context is very different, a country like South Africa shows a similar pattern. Despite pursuing an economic policy that seeks to straddle the development gap both within the country and in its relation to the industrialised world (the Accelerated and Shared Growth Initiative for South Africa or ASGISA), there is growing inequality (including in health care) a burgeoning crisis of disease and no political will or capacity to tackle it.

In both countries elements of the health crisis can be linked to the economic transitions underway, and particularly to the

rapid movement of people to urban areas. In South Africa this movement started in the last decade before the end of apartheid but has accelerated since.⁹

In China the phenomena post dates the turn to a market economy. But in both countries the failure to recognize that the intensification of poverty and inequality, as their economies grew, would have dramatic consequences for health has carried through into a failure of governmental planning for health.

In South Africa, where fortunately health information is more easily available than in China, this is now obvious from a range of indicators, including.

- HIV prevalence amongst adults of nearly 20%;¹⁰
- Low Tuberculosis (TB) cure rates, combined with HIV, have led to a re-explosion of the TB epidemic¹¹ and, more recently, spawned outbreaks of Multi (MDR) and Extremely (XDR) drug resistant TB.

Inequality in access to health and state of health is growing. Although the democratic South Africa adopted a Constitution that grants “everyone” a right of “access to health care services”, and enjoins the state to take “legislative and other measures to progressively realize this right”¹², in some places the quality of the public health system has degenerated to levels worse than experienced under apartheid.¹³

For example, based on her own horrific experience Phyllis Ntantala - the mother of ANC NEC member Pallo Jordan — described public hospitals in the Eastern Cape as “places of death, not life.”¹⁴ The difference with apartheid, however, is that marker for inequality is now class rather than race - however given the huge overlap between being black and poor, the change is not great.

In South Africa, reflecting a pattern that is common to most African countries¹⁵, spending on health care by the 15% of the population with access to private care is approximately R40 billion per annum - about the same amount as is budgeted by government on the 70 to 85% dependent on the public sector.¹⁶ Unfortunately, the fact that South Africa has one of the largest public health infrastructures in Africa, and a per capita expenditure on health that places it amongst many “middle income” countries, hides this inequality. Deduct expenditure on private health and per capita expenditure is much lower. Add to this the health instability caused by the economic and political transition, and it becomes less surprising that our health outcomes are significantly worse than ‘comparable’ countries. This is a strong pointer to the fact that there is no simple equation between poverty and poor population health. Similarly, that higher levels of health expenditure (not disaggregated according to how and where and in what context the spending takes place) do not create a gradient to better health outcomes. Population health is politically determined. It must be planned for and managed. Generally it is not.

Why is this and what can be done about it?

The Rise and Fall of World Health

In a study of the modern history of disease and its coincidence with and contribution to the rise of the modern state, Mark Harrison states that:

“..disease was central to the development of modern states and their machinery of government. From the Renaissance onwards the control of diseases became one of the most important functions of the state,..”¹⁷

Later in the book Harrison concurs with “the traditional position that the chief cause of mortality decline was growing state involvement in public health.”¹⁸

However, if this was the case for five centuries and was particularly the case at the beginning of the twentieth century, it no longer seems to be the case today. In fact, in many ways, whilst national states have retained those accoutrements they need to protect themselves, such as standing armies, they have neglected or privatised those that have become surplus to requirement - such as health care systems. In the words of Scott Burris there has been “a practice of transferring traditional state functions to non-state actors.”¹⁹ Publicly funded health care and education are two such functions

Within the broader ambit of health care, the trends in research and development of new medicines illustrate this point. At the start of the twentieth century governments of industrialized countries, particularly in Europe, invested heavily in medical research that contributed significantly to breakthroughs in areas such as the treatment of TB. For example, in a 2004 report (prepared for the European Union) Richard Laing refers to European health care system as having “a long tradition of social solidarity in which national health systems were developed to create social safety nets for all citizens”. However, the report attributes the dramatic decline in pharmaceutical innovation from the early 1990s (p8), at least in part, to declining investments by European governments in pharmaceutical research, development and application.²⁰

Except in times of crisis or threat, the dominant politics of health care seems to be one where responsibility for the

protection, maintenance and continual improvement of public health is increasingly being separated from the state. In the 'first world' this was driven by a complacency that infectious disease (the initial stimuli to the development of health systems) has largely been conquered. However, as a number of writers have suggested in their attempts to construct arguments to persuade powerful states to reprioritize health and health funding, the ever present threat of 'tropical diseases', pathogens such as the much hyped strain of avian influenza, H5N1, and others yet to be named, might cause states to rue the day. ²¹

It is important here to distinguish the governmental response in the USA or UK to threats such as SARS or H5N1 from the historical relationship between the state and health described above. Writers such as David Fidler²² are correct to point out that this has contributed to the US government and the EU assuming new responsibilities for health. However, this is for the narrow purpose of disease control and the traditional purpose of protecting economies, rather than a reflection on a renewed commitment to health generally.

It does not detract from the argument that in the last twenty years industrialized countries have completed the transition away from proactive state-driven strategies aiming at disease prevention, to a largely passive and technical approach to managing the maintenance of health systems and infrastructure, and staying off periodic disease outbreaks. It seems that as long as major public health threats are held at bay, the actual health of persons (who are getting less healthy, but no longer primarily as a result of communicable disease), is of less concern to the state. ²³

Thus, within developed countries, but in significantly varying degrees, the state supports health systems that maintain a high standard of health care 'at home', such as the National Health System (NHS) in England or Medicaid in the USA. Compared with health systems in the third world, they offer an undreamed of standard of care. However, they too have been the subject of attack by governments that has reduced the quality of care and, in countries like the USA left millions of people uninsured and grossly discriminated against in access to decent health services.

But even the praiseworthy parts of these health systems, and the way they are managed by government, overlooks how infectious and communicable disease (which has always been global, but was once more easy to quarantine²⁴) can take advantage of the explosion of inter and intra-national travel to move pathogens swiftly from causing localized to globalised epidemics. In most industrialized countries the government seems to believe its duties to provide health care, its budgetary responsibilities and health policies end abruptly at national boundaries - boundaries that viruses and bacteria pay scant attention to. What happens on the other side of these porous borders is the responsibility of departments providing 'development aid', not health.

National Health services are not linked into an integrated global strategy on health that recognizes the transnational nature of both good and bad health. Although the world has learnt to acknowledge of the impact of health on development - for example the Millennium Development Goals' (MDG) include a number of health indicators - there is still no globally agreed political strategy on states' duties to tackle health or the interventions and standards that will be required to achieve the MDGs. Indeed, there are some who make a cogent argument that the construction of the health MDGs was done in such a way as to make their realisation impossible and to further entrench the systemic inequalities that contribute to bad-health across the globe. ²⁵

So, although funding for health programmes (particularly the prevention and treatment of HIV/AIDS) represents a growing portion of development aid,²⁶ its implementation is usually through vertical programmes, that try to ignore or work around the political paralysis on health.

One consequence of this is that foreign assistance for health is rarely driven by precisely identified and quantified local needs, but is driven by what external organizations consider those needs to be. New imbalances and inequalities in the system arise because finances end up being transferred only to those organisations in recipient countries who have the capacity to design and (usually) implement these programmes. This leads to distortions and imbalances at a local level. Another symptom of the want co-ordination in the financing of health is revealed in an article about funding for TB which showed how one disease, HIV, can squeeze out another in the 'competition' for donor funds.²⁷ Given that TB is the primary cause of death in people with HIV, this distortion is particularly grotesque.

Ironically therefore the wheel has come full circle: today, by omission, in both the industrialised and developing world, the politics of the modern state and government remains a primary determinant of health.

Developing Countries: Health at the Margins

The predominantly laissez faire approach to health adopted by industrialized country governments is mimicked by the governments of most developing countries. These countries replicate the 'first world' approach to health by attempting to

maintain expensive but still under-funded tertiary care systems in urban centres (wrongly considered to be the template of a health system), whilst throwing in an ingredient of what Sanders et al describe as 'selective primary health care'.²⁸ Following the Declaration of Alma Ata in 1978, made at the International Conference on Primary Health Care,²⁹ the strengthening of primary health care was considered the key to unlocking many of the solutions to the world's health problems, and as a route to the realization of health as "a fundamental human right". It was also considered to be a system that would be both affordable and appropriate for developing countries. However, in its implementation the concept of primary health care has been starved of imagination and funds. It has been perverted to justify the existence 'health centres' or 'clinics' that are close to 'the community' but under funded, ill-equipped, under staffed and rarely involved in community health promotion.

In South Africa, for example, a 2007 report by the South African Human Rights Commission (SAHRC), whilst admitting that primary health care clinics constituted only 50% of the facilities it visited, found that:

"many patients are by-passing clinics and going straight to hospitals. This seems to indicate that despite clinics being geographically accessible they are unable to meet patient needs."³⁰

In a similar vein, the District Health Barometer, 2005-2006, published jointly by the Department of Health and Health Systems Trust, an NGO, found significant inequalities in per capita expenditure between health districts and, predictably, significant variations in health outcomes.³¹

Finally, what is most noticeable is that population health, or public health, is rarely regarded as a political priority by developing country governments. Planning to improve health is not integrated into development or economic planning, or vice versa. For example, in South Africa the media statements that are released after every meeting of the Cabinet reveal no records of discussions of health broadly. Although there are discussions about HIV/AIDS, generally these have only taken place at points when the criticism of the country response to HIV/AIDS generated by activists has forced a defensive discussion.

In President Thabo Mbeki's annual 'State of the Nation' speech to Parliament, given in February each year, the issue of health only ever occupies a fraction of the time given to matters of economy, international affairs and poverty, and is often treated separately from these.³²

In addition, the actual impact that poor health has on society, the numbers of people dying, and the causes of illness and death are hidden under broad generalizations about "the burden of disease impacting on our people, including AIDS" (2004)³³

and "broad trends in mortality" (2005)³⁴. Unbeknown to 99.9% of the South African public the 'broad trends in mortality' were an oblique reference to an official report, seen and for some time suppressed by Mbeki, that had shown a 57% increase in adult mortality between the years of 1997 and 2003.³⁵

The low prioritisation of health is borne out by the way in which, in many countries, poor performance and corruption is tolerated from Health Ministers and their departments. South Africa, once more, offers a case in point.

Evidence of the wholesale deterioration in health outcomes, gross mismanagement of budgets³⁶ and the flight of health professionals from the public health sector, have all been insufficient to dislodge the incompetent Minister of Health, Dr Manto Tshabalala-Msimang from her nine year rein. In August/September 2007 there were calls for her dismissal from every corner of society after media revelations that she was 'a thief and a drunk'.³⁷ But she keeps her post primarily because of her political loyalty to Mbeki. Not only that: South Africa's President, oblivious to the reality of public health, defended her by stating that:

"The Presidency would like to reassure all South Africans of the integrity of the public health system as led by Minister Tshabalala-Msimang and the Cabinet collective."³⁸

But the political controversy in South Africa reflects a deeper trend. As a rule, developing country governments approach health reactively rather than proactively. This is evidenced by the almost complete dependence on foreign donors for health investment in many African countries; the absence of serious and consistently driven public health strategies; the acceptance of very high rates of maternal mortality (a symptom of the lower value attached to women generally); the neglect of primary health care; and the failure to control infectious diseases.

Why is this? Developing country governments cannot feign ignorance about the linkages between politics, health and development.³⁹

A succession of commissions and their reports, particularly the WHO's 2000-2001 Commission on Macro Economics and

Health (CMEH) and the 2005 United Kingdom sponsored Commission on Africa have drawn attention to the linkages. The report of the CMEH is worth quoting at some length. It says:

“The wisdom of every culture teaches that “health is wealth” in a more instrumental sense as well. For individuals and families, health brings the capacity for personal development and economic security in the future. Health is the basis for job productivity, the capacity to learn in school, and the capability to grow intellectually, physically and emotionally. In economic terms, health and education are the two cornerstones of human capital, which Nobel Laureates Theodore Shultz and Gary Becker have demonstrated to be the basis of an individual’s economic productivity. As with the economic well-being of individual households, good population health is a critical input into poverty reduction, economic growth, and long-term economic development at the scale of whole societies. This point is widely acknowledged by analysts and policy makers, but is greatly underestimated in its qualitative and quantitative significance, and in the investment allocations of many developing country and donor governments.”⁴⁰

In the face of this mountain of evidence, argument and information, it remains to try and understand the political reasons why in so many countries national health (aggregated to global health) is failing so signally? Is there an explanation other than the wiles of politicians? Why has a period in history that has seen the advance of democracy been accompanied by declines in health? Why have the citizens of the new democracies not forced health into greater focus?

Changes in Production: Globalisation and its Consequence for Public health

Throughout history economic expansion has spread disease.⁴¹— Indeed, as Harrison points out, important features of the modern state arose from the need to prevent and treat disease. Preventing armies and navies, settler populations, and the aristocracy, from being wiped out first by foreign diseases about which there was no knowledge, or for which they had no immunity, was a necessity both for the ‘progress’ of colonialism and the further expansion of capitalism. This necessity led to vaccination campaigns, investment in water and sewerage systems, public health legislation and the creation of rudimentary public health services.

Today, in contrast, there is a deficit of co-ordination, investment and planning in health. Ironically, however, the reason for this continues to rest in the relationship between national governments and economic expansion - just as it did when economic expansion necessitated governmental intervention in health.

In his 2002 book, *Marx’s Revenge*, Meghnad Desai may be stating the obvious when he points out that:

“Capitalism is not a kind or a benevolent system. [But] It is the most effective mode of production discovered so far in wealth creation. It has no overarching objective since it works through the profit-seeking efforts of millions of capitalists. It generates economic growth, prosperity, employment as side-effects. It also causes much misery and destruction in its tendency towards incessant change.”⁴²—

Obvious though they may be, these words may offer guidance to a discussion on the determinants of health.

Everyone agrees that important changes in economy and society have taken place in the since the late 1980s - sometimes crudely linked to events that marked the end of Stalinism and the ‘triumph’ of capitalism. In particular revolutions in technology and communications have become the primary driver of globalization - at this stage of world history. The means of production (and thus of profit) more and more capital intensive.

Linked to this the end of the ‘cold war’ and the collapse of ‘communism’, has opened borders and markets. This has contributed to a massive expansion in the numbers of people traveling.⁴³— Via travel and communication new technologies have been introduced to new and old markets creating new consumption ‘needs’. These new goods depend less and less on the labour of human beings (which is still, as Marx first claimed, the source of added value) to produce them - making them cheaper. Yet, by virtue of new economies of scale unleashed by the global economy, they can be enormously profitable.

This has diminished the relative importance of human labour to the production of profit and thus wealth. More profit can be made by fewer and fewer people, leaving an enormous surplus population, particularly in developing countries.

In South Africa, for example, despite a decade of rapid economic growth unemployment remains at 40%. The tragedy is that governmental priorities change, or unless government’s are forced to create decent jobs by investing in the fabric of societies (including health), high and permanent unemployment will be a feature of the 21st century economy.

The relevance of this argument to health is that, because of the delinking of the general well-being of the working class— from economic productivity and profit, developing country governments no longer seem to have a material interest in

using the state's resources and power to invest in public health. Today it is successfully achieve economic growth whilst ignoring general population health - an approach that is also possible with corollaries such as education and other areas of social welfare.

A vicious circle has been created where each area of governmental neglect impacts negatively on the other. For example, poor health leads to poor education which leads to poor health, and so on.

If this analysis is accurate, then the disconnect between what is said about health by the world's leaders (whether through the G8, the G77 or the United Nations) and what is done is not so surprising. If it is the case, then it also means that social reforms that are dictated by a different set of principles (I would argue human rights not market forces), will be the only way to revive the world's failing health (but I will come to that later).

This reality may be the fatal flaw in the recommendations of the CMEH. In its executive summary, for example, the CMEH waxed lyrically, but naively, that:

“We estimate that approximately 330 million DALYs [disability adjusted life years] would be saved for each of the 8 million deaths averted. Assuming, conservatively, that each DALY saved gives an economic benefit of 1 year's per capita income of a projected \$563 in 2015, the direct economic benefit of saving 330 million DALYs would be \$186 billion per year, and plausibly several times that.”⁴⁵—

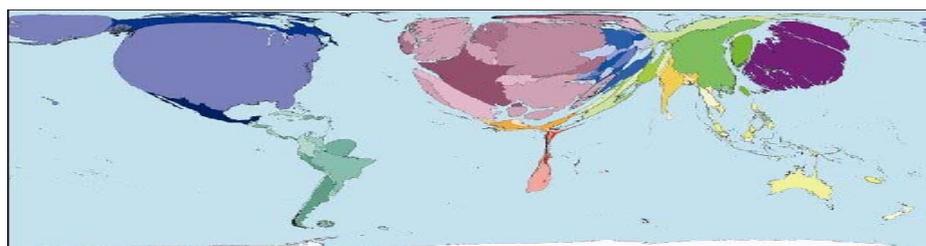
This would seem like a huge incentive to governments to invest in health. The problem is that it is not, because most of those ill and at risk of illness are the *sans culottes*

of the modern economy. Influenced by the thought of people like Jeffrey Sachs⁴⁶ and Amartya Sen,⁴⁷ the CMEH's worthy recommendations assume:

1. that governments attach an economic value to sick people who could be healthy; and
2. that most of the people who are healthy, but poor, will be able to find a place in the modern economy.

But this may not be true. If economic growth can be achieved by relatively small segments of the population utilizing increasingly capital intensive technologies for ever larger markets (markets that by all accounts will continue to grow on the back of China and other emergent economies) then this assumption is mistaken.

Crudely put: illness, whilst causing widespread suffering and indignity, does nothing more to economically disable people who are already socially disabled by the fact that there is no place in the modern economy for them. Could it be that the modern state has no interest, other than a voluntary one, in population health? That would seem to be the only explanation that can help us understand the distortions in public health spending illustrated by the graph below:



⁴⁸
Worldmapper: A Global Map of Public Health Spending—, based on data from UNDP, Human Development Report, 2004.

This want of a strict economic motive for health investment is further compounded by the fact that, in many developing countries, the financial cost of sick people to the state is avoided because the collapse of health services means that most people die at home, burdening their families — but not the fiscus.

In South Africa, as illustrated by the tables below, we have witnessed a dramatic rise in mortality - and obviously morbidity as people succumb to illnesses that eventually cause their deaths:⁴⁹—

Table 3.2 Mortality trends, 1997– 2005

Year	Deaths	Deaths as % of total population	Deaths as % of uninsured population
1997	316 507	0,8%	0,9%
1998	365 053	0,9%	1,0%
1999	380 982	0,9%	1,1%
2000	414 531	1,0%	1,2%
2001	453 404	1,0%	1,2%
2002	499 925	1,1%	1,3%
2003	553 718	1,2%	1,4%
2004	572 350	1,2%	1,4%
2005	591 213	1,3%	1,5%

Source: Statistics South Africa

But despite this, as seen in the next table, there was an overall decline in hospital admissions between 2001 and 2007.⁵⁰—

Table 3.12 Hospital admissions, 2000/01 – 2006/07

	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07
District	1 624 425	1 593 010	1 524 585	1 513 924	1 529 946	1 300 115	1 439 544
Regional	1 388 042	1 545 565	1 487 031	1 518 548	1 463 930	1 507 511	1 327 711
Central and tertiary	568 535	603 677	612 556	599 796	610 344	572 943	698 518
Total	3 581 052	3 742 253	3 624 172	3 632 268	3 604 220	3 380 569	3 465 773

Reclassification in Eastern Cape for 2006/07 accounts for changes between regional and central.

Source: District health information systems, provincial and national departments of health reporting

This suggests several things: that the hospital system is full; that people are being admitted for longer periods (because they are sicker) and that many people are bypassing the lower rungs of the health system to reach the level of central and tertiary care. However, net effect is that sick people are displaced onto their families. Confirming this Statistics South Africa reports that x% of deaths are at home.

One area, however, where the South African state cannot escape a rising cost of ill health relates to social security. Because of the Constitution and its ostensible commitment to poverty relief, South Africa's system of rudimentary grants has become the means by which people claim state support on the grounds that they are ill. Thus there has been a massive increase in the numbers of people claiming disability grants (nearly 1.5 million by 2007) and overall state expenditure on social assistance has risen to 3.2% of GDP. This however is unique to Africa. One also wonders at the logic of paying money to people because they are sick, rather than investing more in health services.

Finally, although bodies like the World Bank and IMF, which have converted to a largely humanitarian interest in health, may bemoan poor health governance, it is in fact their chickens that have come home to roost. The original 'legitimacy' for economic policies that disincentivised and penalized investment in social infrastructure, education and health is found in the debt crisis, structural adjustment etc. However, today it is the logic of the market and the state's surrender to this logic - rather than external conditions - that is a primary determinant of declining health.

Thus, the same logic that works to deny private investment in the research and development of new medicines for the poor (because their sale will yield no profitable return) works to deny public investment in population health - it too will have no direct benefit to the state. It may be a social good, but it is not an economic one.

In fact there might even be a disincentive for health investment, because by lifting one of the major 'unfreedoms' that paralyse poor people's ability to participate actively in politics (rather than just holding their noses and voting), better population health could have negative consequences for 'political stability'.

Shifts towards Global Health Governance: Winds of Change or New Winds of Adhocism?

Some might argue that the analysis/hypothesis I have offered above is unduly pessimistic. They would argue that it is contradicted by evidence of a growing political commitment globally to health. They would, for example, point to the fact that in the first half decade of the 21st century there was evidence of growing concern about the relationship between health and development.

There is no denying that something is happening around health. The HIV/AIDS epidemic, in particular, has forced third world health back onto global political agendas. The death of millions of poor people, mostly from Africa, is beginning to be seen as a morally repugnant blight on the world that, in the words of former UN Special Envoy for AIDS in Africa, Stephen Lewis, "shames and diminishes us all".⁵¹

The pressure of AIDS activists that has dogged politicians since the late 1980s has opened up a space and resources for

new commitments to tackling neglected diseases, including malaria, around which there had been decades of fatalistic resignation and inertia.

Significantly, the focus of activism has shifted from demanding equal rights and non-discrimination for people with HIV in the 1980s and 1990s to demanding recognition of social and economic rights. At the beginning of this century this was mainly with regard to access to medicines,⁵² but increasingly it extends to demands for investment in health systems and health workers.

Activist pressure has reignited debates about health governance. The appointment, in 2002, of a Special Rapporteur on the right to health by the UN Commission on Human Rights⁵³ and the establishment, in 2005, of the Commission on the Social Determinants of Health (CSDH), are positive signals.⁵⁴ So too is the evidence that a number of developing country governments have begun to be more assertive of their duty to protect and fulfill the human right to health, particularly when it comes to the clash between intellectual property regimes and the affordability of essential medicines.

In 2001, for example, at the Ministerial Meeting of the WTO in Doha, developing countries rebelled against the restrictive application of the TRIPS Agreement, leading to a Ministerial Declaration that:

“Each member has the right to grant compulsory licenses and the freedom to determine the grounds upon which such licenses are granted.... Each member has the right to determine what constitutes a national emergency, it being understood that public health crises,...., can represent a national emergency or other circumstances of extreme urgency.”⁵⁵

Further, whilst developing countries initially seemed reluctant to take advantage of this victory, during 2006 and 2007 Brazil and Thailand provoked the wrath of multi-national pharmaceutical companies by issuing compulsory licenses for the essential HIV/AIDS medicines, Efavirenz and Kaletra, and are threatening to do the same with other drugs.⁵⁶ In India, the government successfully defended its intellectual property laws in a court battle instigated by Novartis in connection with its patent on the cancer drug, Gleevec.⁵⁷

These developments looked at one point as if they might revive the global campaign around the rights of governments to protect the right to health⁵⁸ - a campaign that has lost the momentum it gained in early 2001 when over 40 pharmaceutical companies ganged together to try to stop progressive medicines legislation in South Africa.⁵⁹

As another indication of this mood, in May 2007 the World Health Assembly, adopted the WHO’s Medium Term Strategic Plan, 2008-2013, which, amongst other things, makes it a strategic objective ‘to ensure improved access, quality and use of medical products and technologies’.⁶⁰ The WHO will henceforth actively encourage and assist countries to have medicine policies that promote both access and affordability.

Adding grist to the health optimist’s mill, will be the growing number of bi and multi-lateral governmental initiatives around health. For example, in March 2007, the Foreign Affairs Ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand, issued a statement describing governmental omissions on health as “one of the most important, yet still broadly neglected, long-term foreign policy issues of our time” and promising henceforth “to make impact on health a point of departure and a defining lens that each of our countries will use to examine key elements of foreign policy and development strategies...”⁶¹

These political shifts seem to have culminated in late 2007 with the launch of the International Health Partnership and the Scaling Up for Better Health Plan, described by the ITPC as “a cluster of recent global health initiatives encompassing Germany’s Providing for Health, Canada’s Catalytic Initiative to Save a Million Lives, the United Kingdom’s International Health Partnership, and Norway’s Deliver Now for Women and Children.”⁶²

Finally, another feature of the last decade that our optimist will point to is the emergence of a range of governance institutions and vertical health programmes that aim to staunch aspects of the health hemorrhage. Mechanisms such as the Global Fund to Fight AIDS, TB and Malaria (GFATM), the US President’s Emergency Programme for AIDS Relief (PEPFAR), the International Finance Facility and the Advance Market Commitment have stepped into the breach of state and multilateral failures around health.⁶³ Side by side with these are the global health programmes of late-in-the-day philanthropists such as Bill and Melinda Gates and Bill Clinton.⁶⁴

These imaginative initiatives are making a difference and impacting on millions of lives. They are positives, but they also contain negatives. They often fragment and further weaken national health systems by tacitly accepting state failure in

relation to health, and compounding it by often sucking out already scarce health workers out of public health systems.

Global and national health must be assessed not by surface impressions, wishful thinking or academic acrobatics but by critical analysis. Within each of the positive developments are contradictions that give cause for question. Are developing countries such as Brazil and India genuinely pursuing health, or primarily involved in political posturing? Why, despite the rhetoric around the MDGs, and the flurry of new health initiatives, is health aid declining? Why are the governments of Africa not meeting their pledges to increase spending on health as a percentage of total expenditure?⁶⁵

Therefore, much as we might be inclined to be misty eyed about these programmes, the questions that must be asked are (a) whether they sustainable for the few millions that depend on them, and (b) whether they will bring about any change to the ability of government's to the ability to promote and protect health at a national level - or to citizen's power to demand that this is done.

The answer to the first question is uncertain. The answer to the second question is 'maybe - maybe not' or 'it depends'. What it depends on is explored further in coming chapters.

February 2008

¹ Tony Benn, interview in Sicko, by Michael Moore, 2007.

²

In 1997 the UNDP, Human Development Report, warned that HIV was a "new force for impoverishment in sub-Saharan Africa" that would "set off a cascade of economic and social disintegration and impoverishment". In 2007 the WHO, (World Health Statistics, 2007, Ten Statistical Highlights in Global Public Health), predicted "large declines in mortality between 2002 and 2030 for all of the principal communicable, maternal, perinatal and nutritional causes, with the exception of HIV/AIDS." However, the methods by which this conclusion are reached seem highly problematic and would appear to be contradicted by its own evidence.

³

D Durrheim, 'Reducing Poverty by Combating Neglected Tropical Diseases', paper presented to SANPAD Conference, June 2007.

⁴ GAVI Alliance, 'Progress and Achievements, Fact Sheet', Information Current as of January 2007. See www.gavialliance.org

⁵ See www.tac.org.za Electronic Newsletter, 18th September 2005 & Letter to Minister of Health, 17 September 2005.

⁶

C Lougrahn, Infection Prevention and Control Policy in South Africa, unpublished research paper, AIDS Law Project, 2006 available at www.alp.org.za.

⁷ See: 'The Physician Will Not Heal Himself' www.chinadevelopmentbrief.com/node/262; L Jacobs, Between Cultural Relativism and Uniform International Compliance: An Empirical Framework for Judging China's Human Rights Performance, Chapter for M Madsen and G Verginen eds, *Towards a Sociology of Human Rights: Theoretical and Empirical Contributions*, forthcoming in 2008.

⁸ See: J Watts, China's Health Reforms Tilt Away From the Market, www.thelancet.com Vol 371, Jan 26 2008.

⁹ For evidence of the social impact of internal migration see: The Presidency, *A Nation in the Making, A Discussion Document on Macro-social Trends in South Africa*, 2006, p. 55 available at: www.; South Africa Human Development Report, 2003, UNDP, Oxford University Press; UN rapporteur on housing.

¹⁰ Nelson Mandela Foundation, *South African National HIV Prevalence, HIV incidence, Behaviour and Communication Survey*, 2005.

¹¹ The Presidency, Republic of South Africa, *Development Indicators Mid Term Review*, 2007, pp 33-35.

¹² Constitution of the Republic of South Africa, Act 108 of 1996, s 27.

¹³

See, 'Provincial Findings in Preparation for the South African Human Rights Commission Public Enquiry into the Right to Have Access to Health Care Services, Synthesis Report', May 2007, available at: www.sahrc.org.za

¹⁴ P Ntantala, Mail and Guardian, 22 October 2006.

¹⁵

See Commission for Africa, p. 190 "in Africa in 2001 .. only 38% [of health spending] was government spending. 34% was 'out of pocket' spending when ill. These costs are a cause of poverty for some people."

16

17 M Harrison, *Disease and the Modern World, 1500 to the Present Day*, Polity Press, 2004, 2.

18 Ibid, 143.

19 S Burris, Governance, Microgovernance and Health, *Temple Law Review*,

20 R Laing, *Priority Medicines for Europe and the World*, WHO, November 2004.

21 See: Lawrence O. Gostin, Why Rich Countries Should Care About the World's Least Healthy People, *JAMA*. 2007; 298:89-92. L Gostin, "Meeting Basic Needs for The World's Least Healthy People: Toward A Framework Convention On Global Health", Investiture and Inaugural Lecture, Georgetown University Law Centre, April 19 2007.

22 See for example, D Fidler Constitutional Outlines of Public Health's "New World Order", *Temple Law Review*...

23 See as an example, *On the State of Public Health, Annual Report of the Chief Medical Adviser (UK)*, 2005, which identifies obesity, binge drinking, smoking and food purchasing habits as major population challenges for health. Although HIV and West Nile virus receive mention, these are minority problems. See www.dh.gov.uk/en/publicationsandstatistics/publications/AnnualReport/dh_4115776

24 Harrison, pp. 97-105

25

JP Unger argues that the MDG focus on health outcomes, rather than the systems needed to deliver health, encourages vertical, externally driven health programmes, rather than a sustainable investment in the infrastructure and humans needed for health.

26

A recent report has pointed out that within the European Union this is in fact not the case. The report claims that funding for health dropped from 7% of Overseas Development Assistance in 1996 to 5% in 2005 and that "only one third of these commitments were actually disbursed." Action for Global Health, *An Unhealthy Prognosis, The EC's Development Funding for Health*, May 2007.

27 S Kaufmann, S Parida. Changing Funding Patterns in Tuberculosis, *Nature Medicine*, 13, 2007

28 D Sanders, D Werner, *Questioning the Solution: The Politics of Primary Health Care and Child Survival*, HealthWrights.

29 www.who.int/hpr/NPH/docs/Declaration_almaata.pdf

30 SAHRC, , .34

31 www.hst.org.za/publications/701

32 (check SA govt records of Cabinet discussion on health) See www.anc.org/thabo mbeki

33 President Mbeki, Address at the Second Joint Sitting of the Third Democratic Parliament, www.anc.org.za/ancdocs/history/mbeki/2005/tm0211.html

34 www.anc.org.za/ancdocs/history/mbeki/2005/tm_0203.html

35 *Mortality and causes of death in South Africa, 1997-2003*, Statistics South Africa, 2005

36 See: Public Service Accountability Monitor (PSAM)

37 This was the front page headline of the Sunday Times on

38

This Minister was appointed to office in 1999. In the context of a controversy over the firing of the Deputy Health Minister, President Mbeki repeatedly defended her record in the face of evidence of a huge health crisis and growing public outrage about the state of public hospitals. For political background see: How Manto Dodged the Axe, *Mail and Guardian*, 18 May 2007; For examples of President's protection see: *ANC Today*, 29 July-7 August, 2007: 'Facts, Fiction and Miniskirts'; *ANC Today*, 17 - 24 Aug, Who are our Heros and Heroines?; Presidency, Statement on Allegations Leveled Against the Minister of Health, 13 August 2007.

39

Cabinet Ministers and civil society delegations troop in great numbers and with expensive regularity to the WHO in Geneva, to the UN in New York, and to a plethora of largely unnecessary international conferences on aspects of health. The fervor for Dollar per dieums, however, is the primary reason.

40 WHO, Report of the Commission on Macroeconomics and Health, *Macroeconomics and Health: Investing in Health for Economic Development*, 2001, 21-22.

41 See K F Kiple, The History of Disease, in *Cambridge Illustrated History of Medicine*, 1996.

42 Desai, M. *Marx's Revenge, The Resurgence of Capitalism and the Death of Statist Socialism*, Verso, 2002, p. 313. Earlier in the same chapter Desai points out that "the advantages of capitalism - its wealth producing ability, its dynamism, its innovativeness, — are dialectically connected to its disadvantages." (p.295) . He does not say what these are other than "instability and cycles, inequality of wealth and income." However, looking at the recent period of rapid expansion based upon technological change it is possible to say that capitalism both creates ill health, and the means to correct it, and that after periods of expansion, there have - in the past - been periods where societies attempt to mitigate some of the problems, including around health.

43 According to a 2000 report by the CIA every day two million people cross national borders.

44

This term has become outmoded. In developing countries most of the people who were traditionally described as the 'working class' do not work and many are unlikely ever to do so. What we really mean is those who are wholly dependent on their labour to make and - in the absence of employment - are wholly dependent on the state to receive essential social services, such as education and health. The absence of formal employment means that people survive via a range of informal activities, activities that often make them more prone to ill health.

45 Ibid. Executive Summary, pp 12-13.

46 J Sachs, *The End of Poverty*, xxx

47 A. Sen, *Development as Freedom*, Anchor books, 2000. In the chapter on Markets, State and Social Opportunity (at p.143) Sen refers to "the remarkable history of public action dealing respectively with education, health care, land reforms and so on" as making it possible for the "bulk of people to participate directly in the process of economic expansion." In the context of government's contemporary unwillingness to expand internal markets to the permanently poor, this statement may hold a future truth, as well as a past one.

48 See: www.worldmapper.org/display.php?selected=213

49 Statistics South Africa, xxx

50 Treasury, *Intergovernmental Fiscal Report, 2007, Health*.

51 S Lewis, *Race Against Time*, Anansi, 2005.

52 Edwin Cameron and Jonathan Berger, "Patents and Public Health: Principle, Politics and Paradox" (2005) 131 *Proceedings of the British Academy* 331 (also published in David Vaver (ed.), *Intellectual Property Rights* (Routledge, London: 2005)).

53 For information about and the reports of the UN Special Rapporteur see:

www.essex.ac.uk/human_rights_centre/rth/rapporteur.shtml

54 See www.who.int/social_determinants/en

. The CSDH is due to issue its findings in June 2008 - one wonders, however, whether it will tell us anything we don't know.

55

World Trade Organisation, Doha Ministerial Declaration on the TRIPS agreement and Public Health, 20 November 2001, available at: www.wto.org/english/thewto_e/min01_e/minded_trips_e.htm

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See: Medecins Sans Frontieres, Indian Court Ruling in Novartis Case Protects India as the 'Pharmacy of the Developing World', 6 August 2007; www.lawyerscollective.org

Madras High Court Dismisses Novartis' Challenge to the Indian Patent Law, 6 August 2007.

58 TAC Newsletter, 24 January 2007; MSF

59

Heywood, M. 'Debunking Conglomo-talk': A Case Study of the Amicus Curiae as an Instrument for Advocacy, Investigation and Mobilisation, *Law, Democracy and Development*, 5, 2001(2), 133-163.

60 WHO, Medium Term Strategic Plan, 2008-2013, p. 158, see www.who.int.

61 The Oslo Ministerial Declaration, 'Global Health: a Pressing Foreign Policy Issue of our Time'. The www.thelancet.com, April 2, 2007

62 Open Letter to the Leaders Of the Health-8 (H-8) about the *Scaling Up For Better Health* Plan from the International Treatment Preparedness Coalition (ITPC), 17 December 2007.

63

64 See www.gatesfoundation.org and www.clintonfoundation.org

See: African Union, Abuja Declaration on HIV/AIDS, Tuberculosis and Other Infectious Diseases, April 2001 which pledged to set a target of “at least 15% of our annual budgets to the improvement of the health sector.”

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Chapter two: Health and the Inequality of Poverty: Towards a Right-based Convention on Global Health

By Mark Heywood
Created 02/29/2008 - 14:19

Introduction:

This article continues the argument that there is a political reason for deteriorating public health. However, whilst declining health can be partly attributed to political neglect it is not its direct cause. Rather, it is the growth of socio-economic inequalities that are coming about as a result of changed patterns of production and economic growth, combined with human insecurity, that is putting millions of people at risk of ill health and disease. Tackling this requires (a) that health strategies do more to examine inequality¹, and (b) that advocacy for health begins to include robust political advocacy against inequality.

The article tries to justify this hypothesis by looking at some of the drivers of the HIV epidemic in South Africa. Initially drawing on the evidence that links higher risk of HIV infection to inequality I argue that health promotion will be self-defeating if it ignores the link between social and economic inequality and poor health. The currency of such an approach is borne out by people like Paul Farmer who asks rhetorically whether we can address ill health:

“without addressing social forces, including racism, pollution, poor housing, and poverty, that shape their course in both individuals and populations?”²

In a similar vein Daniel Becker, a Brazilian health activist, asks: “How much good does it do to treat people’s illnesses, only to send them back to the conditions that made them sick?”³

The road to health requires that civil society (of all hues) identify and challenge those governmental policies which cause and reinforce inequality -- even whilst they alleviate some poverty. It also requires that pro-poor organizations of civil society pro-poor, including political parties, begin to understand health. Finally it necessitates acceptance of the importance of using the state’s legal and moral power and resources to ensure that government’s carry out their positive duties to protect and promote health, obligations that they have voluntarily accepted under national and international law. This requires community mobilisation to reclaim the national state as a democratic instrument that can deliver on poor people’s needs. One of the most effective ways to do this will be through stepping up campaigns for human right to health both nationally and internationally.

Health without Equality?

Research conducted in a number of developed countries has demonstrated that inequality, rather than just wealth, is a social determinant of health. This is seen to be the case even when the inequality is between people who, comparable to third world standards of living, are socially secure. Thus, Daniels et al point out that “the relationship between economic development and health is not fixed, and that the health achievement of nations is mediated by processes other than wealth.”⁴ Put simply a country may simultaneously be gaining in wealth, and failing in health.

Most, but not all, of the research on which the findings of writers such as Amartya Sen and others are based is drawn from developed countries. However, it is logical to say that when the economic and political policies that are pursued by developing countries contribute to a growth in social inequality, this will have negative consequences for health. This would explain why countries such as China or South Africa, which are experiencing rapid economic growth, simultaneously witness declining population health.

Put another way, economic policies that widen inequality between the monied and the poor and between the poor and even poorer, fuel both disease and ill health.

Research bears this out. So does empirical evidence that is starting to emerge in South Africa.

In 2007 a report published by the South African government found “widening income inequality, particularly between more and less skilled black workers”.⁵

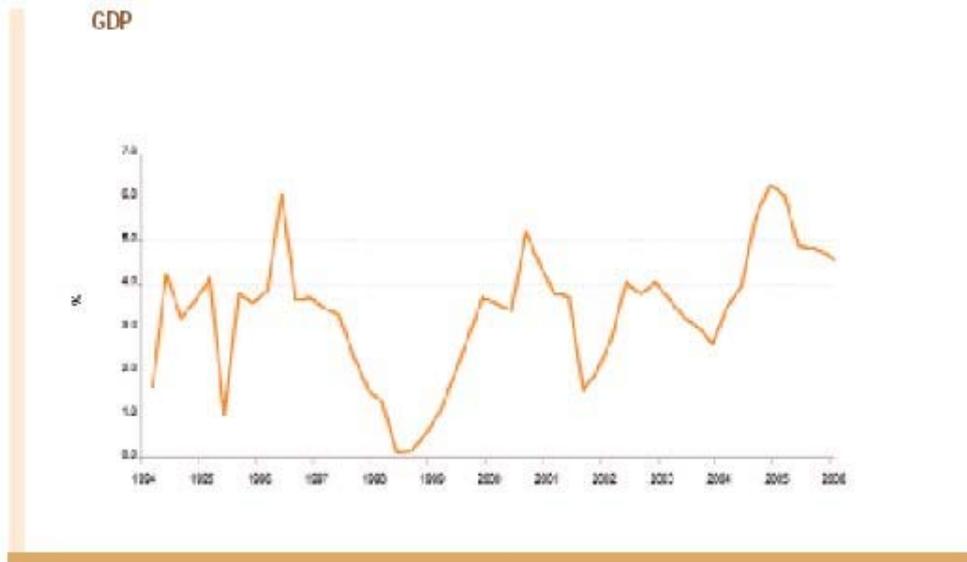
The report added that inequality was not being overcome by “the beneficial impact of social grants and some job expansion”. Significantly, it also noticed that:

Inequality between races has declined, while inequality within race groups has grown. In 1993, 61 per cent of

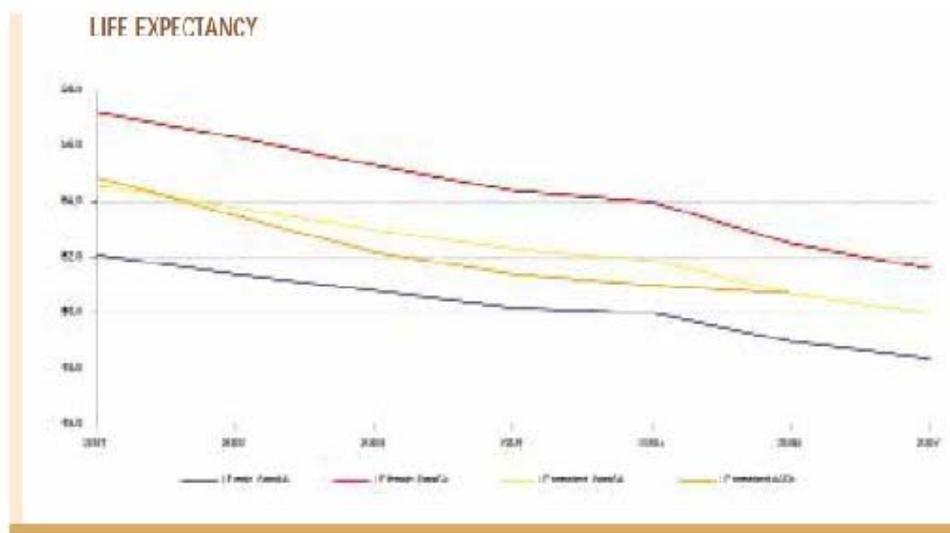
inequality was between race groups, however, by 2006 inequality between race groups had declined to 40 per cent.

Over the same period, inequality within race groups has become much more prominent.

A causal link between inequality and poor health would explain what otherwise would appear to be an inexplicable contradiction about the new South Africa: the country is experiencing progress with key economic indicators (see GDP growth in the table below), and even with many of its social ones (houses are being built, sanitation improved etc). 6



But it is simultaneously experiencing a growing disease burden and, as illustrated below, significantly declining life expectancy. 7



The explanation for this would seem to be the growth in inequality not just between rich and poor, but also within 'the poor'. Inequality, rather than just 'extreme poverty' - as has been claimed many times by South African President Thabo Mbeki⁸ - is a major driver of declining ill health generally and HIV particularly.

This suggests that by itself a strategy that promotes economic growth and seeks to use selective cash transfers (child support grants, foster grants etc) for poverty alleviation will not be an effective HIV prevention strategy, as has frequently been claimed by Mbeki and his acolytes.

Whilst there is a dispute about the depth and breadth of poverty in South Africa even the Presidency concedes that inequality has grown.⁹

There are fewer people classified as living in absolute poverty but more very poor people live side-by-side with less poor people in urban formal and informal settlements all over the country. This growth in proximal inequality creates an immediate vulnerability to disease, however distant its political causes. What do we mean by this?

People's experience of poverty is not uniform. Poverty (like wealth) is layered, with gender and disability in particular being associated with deeper degrees of poverty.¹⁰

For much of the twentieth century women were healthier than men, with longer life expectancies, lower vulnerability to diseases like TB etc. But this appears to be changing, especially in the 'new economies'.

In South Africa the fact that women and girls experience deeper social and economic disadvantage than men and boys, is thought to explain their consistently earlier and higher rates of HIV infection and mortality. In many communities girls and young women, who are the least equal of poor people, adopt survival strategies that are not necessary for others.¹¹ Sex

becomes a commodity they can exchange in return for a degree of social security (or greater equality).¹² This is obtained from men who may be only slightly less poor (because they live in the same community), but whose access to income is linked to their gender, limited access to the economy and often slightly older age.

The links between inequality, gender and ill health are well supported by research. Historically the migrant labour system, and its enforcement by apartheid laws, penned millions of women into rural areas. Today migrancy – although of a different sort -- remains a major risk for disease.¹³

However, the situation has become even more complex. Mark Hunter, for example, has argued that in the post apartheid years changes to the South African economy have created “a changing political economy of sex”.

“It is clear that most African women today are no longer waiting in rural areas to be infected by their migrant partners, the pattern of infection described convincingly in the 1940s for syphilis and often evoked uncritically in the contemporary period.”¹⁴

Women are as poor as they were under apartheid but more mobile, making them much more the active agents of their own vulnerability.

Social instability means that awareness of HIV, when it is not accompanied by access to income, a dependable justice system that can prosecute domestic violence and rape and support services for women and girls, will be insufficient to reduce risk behaviour.

On the other hand, as Catherine Campbell has pointed out, poor men are also not immune to behaviors that are directly influenced by their marginalization and inequality. She draws attention to how:

“Frequent and unprotected sex with multiple partners may often be one of the few ways in which men can act out their masculinity. This might be the case particularly in situations where men, at best, work in difficult conditions over which they have little control or, at worst, have little access to jobs and money.”¹⁵

From the above it should be clear that in post-apartheid South Africa poverty, inequality, migration and sex form the locus of a risk to health and well-being. The theatre where this risk is acted out are the communities where people live, but their behaviours (or choices) are being heavily influenced by social, economic and political policies devised and implemented at a national level. To be effective public health strategies must therefore address both national and local issues.

Let me illustrate this with the case of HIV where the vicious circle that must be broken can be summarized as follows. For many people, vulnerability to HIV starts by being driven by external factors (inherited disadvantage together with contemporary political and economic policies that exacerbate inequality). However, once this risk has translated into HIV infection, then actual poor health, caused by HIV, provides its own internal motor to the cycle of inequality. Thereafter unless people have access to health care services that provide treatment and care, illness adds to pre-existing deprivation. Being sick incapacitates people, creates new needs and diverts household resources. HIV infection becomes not just a symptom, but an agent, of inequality. It must therefore be challenged on two levels: *directly* through traditional public health campaigns to diagnose, prevent and treat HIV and *politically* through challenges to the policies that create, or fail to alleviate, the risk.

If you consider that ill-health often robs poor people of their capacity to be politically active because they are made further ‘unfree’ by illness, this is clearly a challenge.¹⁶

But TAC’s sustained and visible community mobilization for AIDS treatment has shown that it is possible (I will explore this more in the next chapter).

The Role of Government and Uses of the State

Because of these connections there is a growing need for health activism to become enmeshed with political activism and vice versa.

In the present global political context, where revolutions in communication have created growing awareness of a range of social issues from climate change to health, and where there can be immediate access to information, there should be growing opportunity for such links to be established.

Unease about the post-1990 phase of globalisation has created a new theatre for social justice activists. It has spawned institutions such as the World Social Forum and the People’s Health Movement. But despite this health remains isolated in from campaigns for equality and justice. The way in which demands for equity and opportunity for good health could be used to mobilize around other social ills, and better other aspects of the lives of poor people, is still largely overlooked.¹⁷

Ill health seems to be regarded by the left primarily as the *consequence* of poverty and inequality, rather than equally as a *contributor*

to it. As a result it is rare to find health advocacy at the centre of the campaigns and programmes of pro-poor and social justice organizations. In recent decades, socialist parties, trade unions and social movements have rarely shown any sign that they appreciate how integral health is to dignity and development. Consequently very few have prioritized and aggressively implemented health programmes and platforms – and the duty of the state in this regard has been forgotten.

Unfortunately there is also evidence that many political activists and analysts seize too quickly on those explanations for poor health that are nearest to hand and which offer grist to their mill about the 'inherent evils' of neo-liberalism and globalization.¹⁸

Of course, there are good reasons to draw attention to the negative consequences for health of structural adjustment, debt repayment and the World Trade Organisation's (WTO) Agreement on Trade Related Aspects of Intellectual Property (TRIPS).

But this is an insufficient explanation for state failure, and if it is the only explanation then it is disarming. In my view declining health is not being caused by globalization alone, but by the *voluntary* retreat of the State from its social responsibilities –sometimes using 'globalization' as a feint for its own omissions.

One consequence of the failure of activists to focus in a sophisticated way on state duties (and on developing alternative policies for governments) is to hand control over the debates about the need to prioritize population health to the very governments and institutions whose policies did the most to begin the reverse of post-colonial health gains in a number of countries – the United States, the World Bank and the IMF.

Albeit not representative of the lowest income countries, South Africa nevertheless gives ammunition to my argument. Since the advent of democracy South Africa has reduced its external debt to 33.5% of GDP (down from 43.5% in 1994) and avoided taking loans from either the World Bank or IMF¹⁹. Relative to other developing countries, its debt burden is not significant, and certainly does not impede social spending.

But despite this, between 1996 and 2000, under an economic policy known as the Growth Employment and Redistribution Strategy (GEAR), the ANC government voluntarily imposed arbitrary limits on public spending on health with profound consequences. Today, even in a period of a more expansionary fiscal policy, the Minister of Health refuses to accurately establish the country's health needs, so that she can properly quantify its human resource or budgetary needs.²⁰

Similarly, despite the fierce rhetoric leveled by the Thabo Mbeki, the ANC, – and other developing countries -- against pharmaceutical company profiteering from medicines, the government has declined to use the flexibilities negotiated, in November 2001, under the TRIPS agreement to issue, or even threaten, compulsory licenses on essential medicines.

For these reasons it is arguable that the political determinants of the health crisis lie as much with the refusal of developing country governments (particularly the so-called emerging economies) to use the State's resources or legal authority to prioritise health in public policy, as with globalisation.

The problem is that most developing country governments are unwilling to act reasonably or systematically to fulfill states' duties in relation to the right to health, despite reams of lip-service to international human rights covenants and national constitutions.

The approach to health adopted by the ANC serves, once again, as an example. In its broad strokes the ANC's health policy has always been rights-based, pro-poor and progressive. The 1955 Freedom Charter, for example, stated:

"A preventative health scheme shall be run by the state. Free medical care and hospitalization shall be provided for all, with special care for mothers and young children. The aged, the orphans, the disabled and the sick shall be cared for by the state." ²¹

However, during the years when the ANC was banned (1960 – 1990) and its leadership in exile or prison, a disconnect developed between those working on and campaigning for population health in South Africa and those in exile.

Consequently, as Leslie London demonstrates, most of the thinking, experimentation and vision-making around health that took place came internally from:

"those health organizations campaigning for civil and political rights (for example, against detention without trial) were also the same groups simultaneously devising policies for primary health care in post-apartheid South Africa, lobbying for a national health service, and joining with civil organizations campaigning for better housing."²²

After the ANC was unbanned in 1990 the gap between internal and external thinking about South Africa's health policy began to be bridged. The main planks and promises of a post apartheid health system were reflected in the ANC's *Reconstruction and Development Programme* which was developed before the first democratic election.²³ This was followed by a broad consultative process that, in 1994, produced the ANC's National Plan for Health (NPH).²⁴ The NPH was detailed and far-sighted on paper, and by 1997 had been translated into a government white paper. Unfortunately though the strategy lacked a plan for implementation and underestimated the opposition it would encounter. As a result, although a raft of pro-poor laws and policies on health have been passed,²⁵ they have all been poorly implemented.

In my view, the ANC should have argued that the legally binding obligations it assumed under South Africa's much vaunted Constitution, and the democratic mandate it acquired over the South African state and its resources, required it to act radically to improve public health. It could also have used the state more effectively as a bulwark against national and international institutions, policies and laws that undermine health. The international backlash that gathered as a result of the 1998 - 2001 litigation brought by the Pharmaceutical Manufacturers Association (PMA) against the SA government demonstrated the

sympathy such an approach would gain internationally. Bold but reasonable measures to advance health would have had the backing of the South African constitution, international law, and a led to a strong moral surge in support of health protection and promotion.

But the ANC leadership chose not to do this, focusing instead on other ‘priorities’ and the mistaken assumption that economic development would trickle down improved health.

As a result social, political and economic policies have had a negative effect on population health, and have not been countered by aggressive health programmes or, except on the issue of HIV, aggressive health advocacy.

The deteriorating health status of the poorest people of South Africa has become clearer and clearer in the last few years. One would have thought that, in the face of the evidence of crumbling health and rising disease related mortality, the ANC would have endorsed a proposal made in May 2007 by former Deputy Health Minister,

Nozizwe Madlala-Routledge, to instigate a systematic review of health policy.²⁶ But instead of being taken seriously the proposal contributed to her dismissal by President Mbeki in August 2007. It was even described by the Minister of Health’s spokesperson, Sibani Mngadi, as a proposal:

“to call in the World Bank to review the national health system. Those familiar with the programmes championed by the World Bank in the rest of our continent will understand that this would have meant the end of such policies as free healthcare for pregnant and lactating women, children under five years and people with disabilities.”²⁷

In keeping with its obliviousness to health, the 5-yearly policy review process undertaken by the ANC in 2007 was also a missed opportunity to revitalize its commitment to health. For example, although the ANC’s Policy Discussion Document on Social Transformation, says “Education and health must be prioritised as the core elements of social transformation” it does not say why or how.²⁸

The links between poverty, homelessness, joblessness, inferior education and ill health are missing. Consequently, the resolutions on health that were adopted by the ANC’s 52nd National Congress in December 2007 are lack-lustre and without depth.²⁹

Where does this leave us?

Human Rights and State Duties

For those who are committed to public health and social justice a debate about the possibility of using ‘the human rights approach’ as a way to impress (and if necessary compel) government’s to fulfill their duties is overdue.

In a May 2007 article criticizing Amnesty International’s campaign for the Right to Health³⁰, *The Economist* wrote provocatively that:

“Food, jobs and housing are certainly necessities. But no useful purpose is served by calling them “rights”. When a government locks someone up without a fair trial, the victim, perpetrator and remedy are fairly clear. This clarity seldom applies to social and economic “rights”. It is hard enough to determine whether such a right has been infringed, let alone who should provide a remedy or how.”³¹

The *Economist* was being mischievous. But similar thoughts are articulated elsewhere.³² What the article does draw attention to is the need to try to agree on a definition of the content of crucial socio-economic rights (in order to know ‘when a right has been infringed’) *and*

to link this to the demand for the strengthening of democratic institutions, including legal systems, that are meant to be accessible to people ‘remedy’ violations of human rights.

Intellectual fellow travelers of *The Economist*

would probably not dispute that the major international human rights covenants, and the General Comments of the Committee on Economic Social and Cultural Rights interpreting these covenants, support the principle that if people starve in a country that has a grain surplus (like India) or die of AIDS within proximity of under-utilised private health care facilities (as they do in South Africa), ‘a human right has been infringed’.³³

But they would go on to argue that such a finding is essentially moral rather than legal, and therefore of little remedial value.

There was a time when this was true. However in the last few decade human rights have become more than just ‘pious wishes’. Today there is now a growing body of domestic law on the right to health and state duties. Thus, according to H Hogerzeil et al, “more than 150 countries have become State parties to the ICESCR, and 83 have signed regional treaties. More than 100 countries have incorporated the right to health in their national constitution.” In addition, in the last fifteen years in low and middle income countries, there have been at least 71 legal cases around access to treatment, 59 of which were successful.³⁴

In these countries, at least, the justiciability of the right to health no longer seems to be about the ability of a court to determine whether a right has been infringed (as claimed by the *Economist*). Rather, the problem revolves around how a court can meaningfully remedy infringements of the right to health and ensure the enforcement of orders made by the Court. It also about how to persuade states to comply with positive duties in the first place – duties they have explicitly assented to through the ratification of international human rights Covenants, Treaties and Declarations such as the 2001 UNGASS Declaration of

Human rights can assist with this. Like the notion of the 'rule of law' human rights have been evoked for several centuries. However, both have been buzz words of the post 1990 World Bank-IMF-EU-USA facilitated 'democratization' of states in Africa, Asia, Latin America and Eastern Europe. Predictably this gives rise to suspicion. But the fact that human rights and rule of law have been packaged as part of the neo-liberal 'development' agenda does not make either concept fundamentally neo-liberal. Debates about human rights have gone through many permutations. But, at heart, advocacy for human rights was borne out of injustice and was intended to correct it.

Today it is possible for civil society organizations to draw ever greater attention to human rights violations. Ironically this has been assisted by globalization and the possibility to globalize the local through access to the internet. This strengthens our ability to more effectively assert that government's have positive duties to respect, protect, promote and fulfill these rights.

This could therefore be an era of opportunity for human rights advocacy for the protection and promotion of health. However, many academic writers on health appear to be in a quandary on this issue. Most academics either ignore human rights, are skeptical about them, or advance wishful-thinking based theory with no guide about the how. David Fidler, for example, worries whether human rights will become "a morally compelling but politically ignored mantra, as perhaps has been the fate of the global human rights strategy on HIV/AIDS."³⁵ Aginam says we should "de-emphasise justiciability and stress human dignity, indivisibility and the interdependence of all human rights."³⁶

Then, most recently Lawrence Gostin, one of the architects of the human rights approach in relation to HIV/AIDS,³⁷ questions the value of human rights as a means to protect and improve health (as opposed to being just a powerful discourse).³⁸

In an important article arguing for a 'Global Framework Convention on Health', Gostin laments that the WHO has "shied from [human rights based] rule making" and seen "itself principally as a scientific, technical agency."³⁹ He does not mention that the WHO was set up with one objective: "the attainment by all people of the highest possible level of health", or that its third principle was that "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."⁴⁰

But what Gostin and others miss is that in the period of (what academics who like to confuse ordinary people call) 'post-Westphalianism' (meaning simply the period of the rise of multi lateral institutions under the auspices of the UN) is that during the 'cold war' the human rights principles that underlay bodies like the WHO were sacrificed to the politics and horse-trading of governments. As a result, in the words of Gregg Gonsalves, UN bodies saw themselves:

"MOST critically as responsible to their member states, NOT those that live within those states. This for me is a fundamental misunderstanding of UN agencies, who are "meta-state" actors, they aren't independent agencies on health (e.g. WHO) etc, but agents of member states and thus doing the bidding of the states that govern them."⁴¹

It therefore not surprising that eventually in a dramatically changed political, social and epidemiological environment "social activists ... turned to the language of human rights to articulate their aspirations for global health."⁴²

However, Gostin and others get snared in a web of codas that makes it hard to see the wood for the trees. He worries that "recasting the problem of extremely poor health as a human rights violation does not help." He is concerned that the theories of justice that are entrenched by human rights cannot help either because under international human rights law states' duties are first of all to their own populations.

He says:
"States may owe their citizens basic health protection by reason of a social compact. However, positing such a relationship among different countries and regions is much more complex."⁴³

He thus struggles to find a ground in law or human rights to his support his argument that rich governments need to accept that they have a duty towards the health of poor countries. Strangely, he overlooks the finding of the Committee on Economic, Social and Cultural Rights that:

"in accordance with Articles 55 and 56 of the Charter of the United Nations, with well-established principles of international law, and with the provisions of the Covenant itself, *international cooperation for development and thus for the realization of economic, social and cultural rights is an obligation of all States. It is particularly incumbent upon those States which are in a position to assist others in this regard.*"⁴⁴ (my emphasis)

Finally, like others⁴⁵ he laments that the right to health is "progressively realizable". The fact that state's duties are tied to "available resources" leaves violator states with a large and legally ambiguous area in which to justify their omissions.

The argument of Gostin and others boils down to a plea that on the basis of morality and enlightened self interest rich states should be beneficent and accept a duty to assist poor states to attain a threshold of service provision in areas such as health.

This approach ends up resting heavily on a dependence on a fickle global charity, rather than global responsibility/duty or encouraging citizens to demand their rights to health and hold governments to account.

And finally the wheel come full circle and we find our way back to developing country governments where Gostin implies there is limited agency, capability and capacity to improve public health, But this is only partially true. His argument about lack of resources and capacity to provide for health is certainly valid in some of the world's poorest and most indebted states. But it does not apply to several key emerging economies where the problem is firstly a lack of governmental will to provide health care services, rather than 'available resources' or capacity.

In these countries the question is whether civil society is able to exert the necessary pressure, supported by international opinion and law, to force governments to do more to address public health. Admittedly, community mobilization for the human right to health will be difficult in countries which continue to suppress democracy and fundamental human rights such as China⁴⁶, Pakistan and Zimbabwe⁴⁷. However, in countries such as South Africa, India and Brazil, which have populations numbering hundreds of millions and a high burden of disease, the right to health can be pursued through a social mobilization that also targets the institutions of the democratic state, such as the courts, human rights commissions etc.

UN Framework Convention on Global Health

Prematurely writing off the legal and political force of using human rights (in various ways) to compel governments to take measures to make health care available, accessible, acceptable and of good quality undermines Gostin's main (and important) argument about the need (arguably the duty under international law) to establish a United Nations Framework Convention on Global Health (FCGH). Indeed, the strongest argument for such a Convention lies in the fact that many States' cannot or are not meeting their national duties as set out in documents such as CESCR General Comment 14 on the right to health. An international agreement has become necessary to set vital health standards and regulate the growing inequalities in the production and distribution of health care.

The human resource crisis is a telling example. Based on CESCR General Comments 3 and 14 it is arguable that in accordance with international human rights law the right to health creates a duty on states to begin to develop and co-ordinate a global plan for the production and equitable distribution of sufficient health care workers⁴⁸. At a minimum it requires an international agreement on standards of remuneration of health care workers, as one way to remove the lure that pulls many health workers away from developing countries. This is necessary because experience has already demonstrated that good intentions, or even voluntary bi-lateral agreements such as that entered into between Britain and South Africa in 2003,⁴⁹ are not enough on their own to alter the global health market's pull of health care workers out of developing countries, into industrialized countries where health workers earn much more and work in much better conditions.⁵⁰ Indeed, a recent research report, quotes official estimates that by 2020 the United States will have a shortage of 800,000 nurses.⁵¹ The effect of this 'market' (when left unregulated) is to make the realisation of the right to health impossible in developing countries – and ironically even more dependent on aid for health.

Some people will reply by saying that the capacity to produce and sustain a health work force is primarily a national duty. This is undoubtedly true. But if a FCGH included standards on health care remuneration, conditions of employment etc, this would boost national efforts to retain health workers, and allow better planning for local production.

Although this might sound radical, it could also formalise an international benchmark for the minimum required expenditure on health per person per annum in order for a state to be able to meet basic health needs – perhaps at around \$100.⁵² The aim of a FCGH should be to collate existing norms and agreements on State duties in relation to health and transform them into standards; to examine the plethora of soft law that exists in order to determine and set standards regarding the 'minimum core content' of the right to health ⁵³ and thereby elaborate on what positive and negative duties the right to health places on governments and other actors, including multi-national corporations.⁵⁴

Most importantly, from my perspective, a FCGH would empower civil society and the health professions in their struggle with their own governments for national standards in health, in a way that the health related Millennium Development Goals (MDGs) are structurally incapable of doing because they are set around vertical targets, rather than standards or systems.

Significantly, as Gostin points out, there are precedents for such definitive agreements – although few that are explicitly based on human rights, and some that deliberately overlook them. The WTO TRIPS agreement, for example, sets a global standard for intellectual property protection, but is silent on its impact on health or human rights. The UN Framework Convention on Climate Change (UNFCCC) (despite having its Kyoto protocol undermined by the United States) can, to its credit, claim to have established a binding agreement which by December 2006 had been adopted by 169 countries.

In the realm of health, the Framework Convention on Tobacco Control (FCTC) is described by the WHO as “a binding international legal instrument which establishes broad commitments and a general system of governance for an issue area.”⁵⁵ However, because of the political neglect of health (as explained in chapter one), it seems unlikely that a FCGH will be brought into existence if left to governments alone. Pressure for such a Convention needs to come from below, from the populations who most need it and the organizations and campaigns that try to represent their needs.

In view of this, in the next chapter, I will look at the experience of the Treatment Action Campaign (TAC) in South Africa, and argue that it is emerging as an example of what can be achieved at a national and local level by using a combination of human rights advocacy, social mobilization and law to advance the struggle for better health. I will also argue that, if its achievements are to be sustained over years to come, the globalized nature of some of the major determinants of health necessitates international regulation.

ENDS

1

In October 2007 the Council of Science editors organized a global theme issue on poverty and human development in which science journals throughout the world published articles on this subject. See www.councilscienceeditors.org/globalthemeissue.cfm

2 P Farmer, 'Structural Violence and Clinical Medicine', *Plos Medicine*, October 2006, Vol 3

3

Daniel Becker, Centro de Promoção da Saúde (CEDAPS) Health, Equity and Social Determinants, presentation to the University of Nijmegen, 23 May 2007.

4

Daniels N, Kennedy B, Kawachi I. Health and Inequality, or, Why Justice is Good for Our Health' (p 67) in S Anand, F Peter, A Sen, *Public Health, Ethics and Equity*, Oxford University Press, 204.

5 The Presidency, Republic of South Africa, *Development Indicators Mid Term Review*, 2007,

6 Ibid

7 Ibid,

8 See T Mbeki, Speech at the Opening Session of the Thirteenth International AIDS Conference, July 2000, www.anc.org.za/show.php?doc=ancdocs/history/mbeki/2000/tm0709.html

9

See ANC Today, Volume 7:45, Nov 2007: "the rate of improvement of income for the poor has not matched that of the rich, and thus while income poverty is declining, inequality has not been reduced."

10 The association between disability and poverty has not been properly studied or quantified in South Africa.

11

It is important to note that by 'survival' I do not mean solely ensuring access to food, but also access to other commodities and resources that define modern living, and which very poor people see all around them, but lack money to acquire.

12

Research recently conducted in Swaziland and Botswana bears this out. Weiser SD, Leiter K, Bangsberg DR, Butler LM, Percy-de Korte F, et al, *Food Insufficiency Is Associated with High-Risk Sexual Behavior among Women in Botswana and Swaziland* *PLoS Medicine* Vol. 4, No. 10, e260 doi:10.1371/journal.pmed.0040260

13 See Mark Lurie's "Migration and HIV/AIDS in Southern Africa: A Review" *South African Journal of Science* 96 (2000).

14

M Hunter, The Changing Political Economy of Sex in South Africa: The Significance of Unemployment and Inequalities to the Scale of the AIDS pandemic, *Social Science and Medicine* 64 (2007) 689-700.

15 C Campbell, *Letting Them Die, How HIV/AIDS Prevention Programmes Often Fail*, The International African Institute, 2003, 184.

16

Amatya Sen has described ill-health as a form of 'unfreedom'. However, as far as I know there is no research looking at actual levels of population morbidity, how many hours of avoidable labour this adds to the lives of carers, and what impact this has on human capacity to protest its condition etc.

17

In a chapter in xxxxx there evidence is provided to show how re-distributive economic policies have a positive outcome on

health (See Sen et al). However, as I show in the next chapter of this article, campaigns for health sometimes also bring about economic and social redistributions.

18

South African economist Patrick Bond is a case in point. In 2003 he questioned TAC's ability to compel the SA Government to introduce a national anti-retroviral treatment programme, something that happened later in the same year. In a mea culpa (Z Net Daily Commentaries, *Can Victory on AIDS Medicines Catalyse Wider Change?*, Dec 1 2003) he nonetheless concludes: "Such socio-economic human rights can be won, in my view, only through deglobalisation, namely the delinking of countries and regions of the world from the bureaucratic straightjackets designed in Washington and Geneva-structural adjustment, TRIPs, etc-on behalf of corporate interests."

19 The Presidency, Republic of South Africa, *Development Indicators Mid Term Review*, 2007, p 10.

20

See address by the Minister of Health to the SA Human Rights Commission, 30 May 2007. In response to a presentation made by the AIDS Law Project arguing that health budgeting is arbitrary and not based on a determination of health needs (see www.alp.org.za), she asks:

"do we need to get into an exercise, which will be very expensive and costly, of determining for all these areas and others the extent and the resource requirements of the backlogs, in order to determine needs based budget for the realisation of the rights in the Constitution?"

She does not answer her own question.

21www.anc.org.za/show.php?doc=ancdocs/history/charter.html

22 L London, **Health and Human Rights: What Can Ten Years of Democracy in South Africa Tell Us?***Health and Human Rights, An International Journal*, Vol 8 no 1, January 2006.

23 ANC, Reconstruction and Development Programme, www.anc.org.za/rdp/rdp2#2.12

24 ANC, A National Health Plan for South Africa, May 1994, www.anc.org.za/ancdocs/policy/health.htm

25 Hassim A, Heywood M, Berger J, *Health and Democracy: A Guide to Human Rights, Health Law and Policy in Post-apartheid South Africa*, Siber Ink, 2007 available at www.alp.org.za

26

In an internal memorandum, May 2007, the Deputy Minister wrote of "the urgent need to pay attention to the increasing burden of disease as well as poor health indicators, despite the growing investment in and resourcing of the health system. There is an increase in both communicable and non-communicable diseases and the demand for quality public health services remains significantly high."

27 S Mngadi, Nozizwe: sublime or sub-prime? *Mail and Guardian*, 21 August 2007.

28 African National Congress, Policy Discussion Document, Social Transformation, 2007 www.anc.org.za .

29www.anc.org.za/ancdocs/history/conf/conference52/resolutions-f/html

30

See: Amnesty International, Human Rights for Human Dignity, A Primer on Economic, Social and Cultural Rights, 2006 www.amnesty.org

31*The Economist*, March 24, 2007.

32 See: A Neier, Social and Economic Rights: a Critique: www.wcl.american.edu/hrbrief/13/2neier.pdf. Neier claims that the socio-economic rights in the SA Constitution and Universal Declaration of Human rights "get [us] into territory that is unmanageable through the judicial process and that intrudes fundamentally into an area where the democratic process ought to prevail." But this claim entirely misses the dialectical relationship that should exist in a democracy between legal systems and politics. The two should be part of a continuum and a process for ensuring accountability.

33

Articles 2, 11 and 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) deal with duties of States to assist each other and the rights to 'adequate food' and the 'highest attainable standard of physical and mental health' See: www.ohchr.org/english/law/index.htm

34 Hogerzeil, H et al, Is Access to Essential Medicines as Part of the Right to Health Enforceable Through the Courts, *The Lancet*, Vol 368 July 22, 2006 www.thelancet.com. These cases were in Argentina, Bolivia, Brazil, Columbia, Costa Rica, Ecuador, India, Nigeria, Panama, San Salvador, South Africa and Venezuela.

35 D Fidler,

36

O Aginam, *Global Health Governance International Law and Public Health in a Divided World*, University of Toronto Press, 2005, 36.

37 L Gostin, Z Lazzarini, *Human Rights and Public Health in the AIDS Epidemic*, Oxford University Press, 1997.

38

Gostin, L. Meeting the Survival Needs of the World's Least Health People, A Proposed Model for Global Health Governance, *JAMA*, July 11 2007, Vol 289, 2, 225-228.

39 In an earlier draft of the same article Gostin says the following of the WHO:

“The WHO was founded in 1948 as a normative institution, but its potential has never been realized. The WHO constitution empowers the agency to adopt conventions, which unlike normal treaties affirmatively require states to take action within 18 months. The WHO also possesses quasi-legislative powers to adopt regulations. WHO regulations, unlike most international law, are binding on member states unless they proactively opt out. But despite WHO's impressive normative powers, modern international health law is remarkably thin with only one significant regulation and one treaty advanced in its 60 years of existence.”

40 Constitution of the WHO.

41 G Gonsalves, private communication, 22 February 2008.

42 Gostin

43 Gostin, L. Why Rich Countries Should Care about the World's Least Healthy People, *JAMA*, 2007 Vol 298:1, 89-92.

44

Office of the High Commissioner on Human Rights, *The Nature of States Parties Obligations* (Art 2, para 1) CESCR General Comment 3, paragraph 14.

45 See Obinan, p39

46 In a chapter in a forthcoming book L Jacobs (*Between Cultural Relativism and Uniform International Compliance: An Empirical Framework for Judging China's Human Rights Performance*) points out how whilst China now recognises rights it makes them non-justiciable: “rights are not inherent to the human condition, but are rather specific benefits conferred and enforced at the discretion of the state.” In fact, China is extremely sensitive about human rights activism around health as witnessed in its prohibition of a meeting that was due to take place on HIV and law in August 2007 (China bans AIDS rights meeting, Group Says, *Reuters News*, 27 July 2007).

47 See for example the report of the International Bar Association (IBA) issued on Zimbabwe in November 2007.

48

General Comment 14 of the Committee on Economic, Social and Cultural Rights, ‘The Right to the Highest Attainable Standard of Health’. Paragraph 12(a) states: 12.

The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:

(a) *Availability*.

Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.

49

See Memorandum of Understanding the Government of the United Kingdom of Great Britain and Northern Ireland and the Government of the Republic of South Africa on the Reciprocal Educational Exchange of Health Care Concepts and Personnel, 2003. SA Ministry of Health press statement, 26 October 2007, ‘EU Urged to Consider Ethics of Recruiting from developing countries’, www.doh.gov.za

50 See D Mcfarlane, *Africa Staffs the West*, *Mail and Guardian*, 28 October 2007, www.mg.co.za

- “Nearly 235 000 professionals left South Africa between 1987 and 1997. Since 1997, the brain drain has cost the country \$7,8-billion, according to the Paris-based Institute for Research and Development.

- Arabic African countries annually lose 50% of their doctors, 23% of engineers and 15% of scientists. Of all Arab students abroad, only 4,5% return home.
- About 80% of Ghana's doctors leave the country within five years of graduation; and about 25% of all doctors trained in Africa work abroad.

51

U.S. Department of Health and Human Services. "Projected Supply, Demand, and Shortages of Registered Nurses: 2000–2020." Health Resources and Services Administration, Bureau of Health Professions, National Center for Health Workforce Analysis, 2002, cited in: U.S. Based International Nurse Recruiters: Structure and Practices of a Burgeoning Industry, Report on Year I of the Project, International Recruitment of Nurses to the United States: Toward a Consensus on Ethical Standards of Practice, Produced by Academy Health with Support from the MacArthur Foundation, August 2007, available at www.

52

Gorik Ooms points out that there is some unanimity on the \$ rate of per capita health spending at between \$40 and \$80. See G Ooms, Do We Need a World Health Insurance to Realise the Right to Health, Plos Medicine, xxxxx. He also points out that international health assistance was 0.03% of the combined GDP of OECD countries in 2006.

53 See for example UNAIDS/OHCHR, *Revised Guideline 6, the International Guidelines on HIV/AIDS and Human Rights*, 2002, which sets out state duties in relation to access to prevention and treatment technologies for HIV/AIDS.

54

For the application of human rights standards to non-state actors see: 'Human Rights and Intellectual Property', Statement by the Committee on Economic, Social and Cultural Rights, 2001 available at: www. . Also, Commission on Human Rights, 'Economic, Social and Cultural Rights: Norms on the Responsibilities of Transnational Corporations and Other Business Enterprises with Regard to Human Rights', 26 August 2003:

"Transnational corporations and other business enterprises shall respect economic, social and cultural rights as well as civil and political rights *and contribute to their realization*, in particular the rights to development, adequate food and drinking water, the highest attainable standard of physical and mental health, adequate housing, privacy, education, freedom of thought, conscience, and religion and freedom of opinion and expression, and shall *refrain from actions which obstruct or impede the realization* of those rights." (my emphasis)

55www.who.int/tobacco/framework/faq Frequently asked questions on the WHO FCTC and the Context in which it was negotiated

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Published on Treatment Action Campaign (<http://www.tac.org.za/community>)

Chapter Three: South Africa's Treatment Action Campaign (TAC): An example of a successful human rights campaign for health?

By Mark Heywood

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“The Treatment Action Campaign (TAC), ... has shifted the debate firmly to one of fundamental human rights and utilized the human rights machinery established by the same government to force its hand on the ARV issue.”^[1]

Introduction:

In earlier chapters of this article I have argued that a Framework Convention on Global Health (FCGH) must be located in a human rights framework, and that the impetus for it needs to come first and foremost from communities and people that are being denied health care. I also argued that a push for the prioritization of health in national politics would be assisted if there was an international framework that set out global standards and national duties in relation to health. However, these two assertions beg the question as to whether there are successful examples of campaigns for better health that have been driven by human rights and taken advantage of legal systems. If there are, are there contextual prerequisites that will either facilitate or frustrate the use of human rights? What are the ingredients that are required for the successful utilization of human rights demands for health by a social movement?

In this chapter, to try to answer these questions, I examine the experience of the Treatment Action Campaign (TAC) in South Africa and attempt to draw out the approaches behind and factors influencing its activity. A study of comparable movements for health in countries such as Thailand and Brazil would be helpful but is not undertaken here.

Beginnings:

The TAC was launched on 10 December 1998, Human Rights Day in South Africa, by a small group of political activists. The rudimentary consensus within the group was that equitable access to health care, and in particular medicines for HIV, is a human right. In addition the TAC's leaders appreciated that HIV, albeit a virus, is a symptom of deeper social and political crisis that faces poor people, and that the growth of HIV to pandemic proportions is because transmission is often via social fault lines created by poverty, inequality and social injustice.^[2] TAC's intention was to popularise and enforce what was loosely described as 'the right of access to treatment' through a combination of protest, mobilization and legal action.

The founders of TAC had little prior understanding of public health or its politics. Initially, the TAC argued that the primary obstacle to the realisation of the right to health in the context of HIV were privately owned pharmaceutical companies, whose excessive pricing of (and profiteering from) essential anti-retroviral drugs (ARVs) had placed these medicines out of reach of the poor in developing countries.^[3]

Therefore TAC's starting point was that excessive pricing of essential medicines by privately owned pharmaceutical companies violated a range of the human rights that had, since 1996, been entrenched in the South African Constitution, including rights to life, equality, dignity, autonomy and access to health care services. It argued that intellectual property was not a human right, but a device granted by the state for a public purpose.[4]

However, over several years TAC's experience demonstrated that these rights, when seriously pursued, cannot be narrowly contained or their violation assigned solely to profiteering from medicines. Their protection and promotion has implications for the conduct of government in most spheres of life. The rights to dignity and equality, for example, impact upon (positively or negatively) almost every sphere of social life and political governance. TAC also learnt that governmental neglect of health, even by a progressive government such as that in South Africa, can be as much of a barrier to the right to health as profiteering by pharmaceutical companies or aspects of economic globalisation.

Equipping a Movement:

Many civil society organizations internationally locate their activities in human rights, particularly in the vision of the Universal Declaration of Human Rights. As, pointed out by M R Reich, in recent years the notion of rights and their articulation by NGOs has, to some extent contributed to the 'reshaping' of the state as new technologies "have created new sources of power: through the flow of ideas, information, alliances, strategies and money." [5]

However, effective though they sometimes are, most human rights organizations continue to base themselves on advocacy for ideas via an apparatus and a handful of professionals, rather than working with a social movement that becomes its own proponent of the rights of its constituency. TAC has adopted a different approach. From the outset TAC sought to build a capacity to pursue human rights entitlements directly amongst the poor and to catalyse a political movement for health.

Part of the rationale for this was a distrust of the professional 'AIDS and human rights movement' -- unlike academics, or professionals who take up human rights issues out of conscience, poor people require rights out of necessity. Their needs do not disappear when NGO employees change jobs, or NGOs change priorities.

But to do this required that community based activists learn not just an understanding of how to mouth human rights, but also how to apply them as demands in relation to specific social issues. The right to health, for example, cannot be effectively utilized by community activists unless health itself is understood; nor can the right to health be pursued outside of law, politics or issues of governance.

This capability had to be built from scratch. To achieve this TAC became the first AIDS organization to pioneer the concept and practice of HIV 'treatment literacy' in a developing country.[6] Treatment literacy is a programme of health education and communication that aims to educate HIV-vulnerable and poor people about the science of HIV, health and the benefits of treatment. To do this, TAC developed a range of educational materials (including posters, booklets and videos)[7] and combined this with an extensive training programme.[8] People who were trained and satisfactorily completed an internal examination process were appointed as 'treatment literacy practitioners' (known as TLPs) for a year and assigned to clinics, hospitals and community organizations where they conduct further training. They are also linked to TAC's community branches, supposedly the nerve centre for TAC's local organizing.

However, treatment literacy is not taught in a neutral or bio-medical fashion. Information about the science of medicine and health is linked to political science, human rights, equality and the positive duties on the state. In addition, the infrastructure of the programme doubles up as a means for mobilization and local organization.

TAC's high profile campaigns and court cases have garnered much comment and superficial research. But overlooked has been the fact that treatment literacy training has been ongoing behind all of them

Treatment literacy proved to be the basis both for self-help and social mobilization. Armed with proper knowledge about HIV, poor people became their own advocates, personally and socially empowered by the information they received.[9] In the

communities where TAC organized this fed the demand for access to anti-retroviral treatment by people with AIDS at local clinics, leading to higher rates of take-up and adherence than in comparable communities where a TAC branch was not present. But in addition, access to accurate information about health and linking this information to rights, empowered marginalized people who began to assume both a public voice and a visibility.

Gradually this combination of mobilization and education consolidated TAC's membership in a growing number of communities across South Africa. With new tools, a vision and the necessity of gaining access to health care services a new generation of human rights activists came into being. As a result an organizational coherence began to form amongst people living with HIV. Aided by the trade mark 'HIV positive' T-shirt, people with AIDS ceased being silent victims and became political agitators for their human right to treatment.

The results of this approach has relevance for other social justice issues, particularly those that demand that governments pursue social policies that actively aim at creating social justice and dignity, including policies to improve access to quality education and housing, for "sufficient food and water"^[10] and employment.

Indeed, the potential of such an approach is argued for by Colm Allen of the Centre for Social Accountability (CSA) in the Eastern Cape of South Africa. Allen argues that in genuine constitutional democracies such as South Africa's civil society should view the democratic state as a mechanism of enablement, rather than constraint, which should be subject to the pressure of organised civil society so as to ensure the progressive realization of human rights. According to Allen we must ask what:

"democracy actually means in practice and what the implications are for the shape of the democratic state if we are to conceive of this as anything other than repressive constraint on the freedom of individuals, or a tool for the manipulation of social agents. In particular, what are the conditions of possibility for an enabling state with the capacity to effectively and progressively realise the social and economic (as well as political and civil) rights of individuals in line with its available resources."

In his view:

"the purpose of the democratic state, ... is not primarily to provide citizens with a forum for deliberation, participation or co-governance. Rather, it is to provide a mechanism for ensuring the accountable use of public resources for purposes of progressively realising peoples' human rights."^[11]

Of course in countries that do not have a rights-based constitution or legal framework, or which have them but do not respect them, such an approach is not feasible. However, there are developing countries, such as India and Brazil, and even transitional economies, such as China, where such a space either does exist or can begin to be created.

The value of resorting to *universal* human rights as the touchstone for *local* demands is aided by the fact that shared socio-economic deprivations often have shared political roots – and continue precisely because they are not effectively challenged. In India, for example, the problem of permanent semi-starvation that is endured by millions of people has its origin in hunger-denialism (a refusal to admit the prevalence or causes of hunger), similar to the AIDS denialism demonstrated by the South African government. Denialism exists when governments try to create images of economic or political security that do not want to let in truths about the extent of poverty, HIV or hunger. ^[12] Denialism is best overcome by activism.

Strategy and Tactics - The Duties of Government:

In 2003 TAC was criticized by Cameron Dugmore, an ANC member of Parliament, for having a 'narrow' focus on the right of access to anti-retroviral medicines. ^[13] This criticism necessitates a discussion of what strategies will (or will not) legitimate human rights advocacy as a means to pursue claims for social justice.

What Dugmore and others of his ilk miss is that TAC's focus on the right of access to treatment (ARVs) was grounded in the

reality of the AIDS epidemic, rather than public health theory. Pregnant women infected with HIV needed ARVs to reduce the risk of HIV to their babies (known as 'vertical transmission'). People living with AIDS needed medicines in order to stay alive. Availing these medicines to people was the primary task – broader questions about health systems would follow, as they did.

Thus rather than reflecting on a misplaced strategy, TAC's initial campaigns say more about the methods by which social movements can be constructed: people who are directly in need of health care, in this case people with HIV, will mobilize around tangible needs, rather than general and abstract complaints of inequality.

Further, as demonstrated by the huge international wave of concern unleashed in 2001 as a result of the attempt by 41 multi-national pharmaceutical companies to block South Africa's amended Medicines Act, global pressure for changes to health policy is more likely to come as a result of a real community and national mobilization that is driven by people actually needing health care, than if it flows from abstract denunciations of injustice, however true these may be.

It was for these reasons that TAC's first campaign, launched on December 10th 1998, was to demand that the South African government introduce a national programme to prevent mother to child HIV transmission (PMTCT).[14] TAC's call was for access to a simple medical intervention (a short course of AZT), that could significantly reduce the risk of HIV infection from pregnant mother to baby.

The campaign initially focused on the right of access to AZT, because clinical trials had demonstrated that it could reduce the risk of HIV transmission and was feasible for implementation in developing countries health systems.

Initially TAC was told by South Africa's then Health Minister, Dr Nkosazana Dlamini-Zuma, that the primary barrier to the use of AZT was the drug's high price.[15] In response TAC argued that profiteering by GlaxoSmithKline from an essential medicine denied people the right to life – and needed to be challenged.

This campaign caught the attention of young women with HIV and - for the first time in Africa - began to galvanize a social movement around HIV that was made up of people who were predominantly poor, black and living with HIV. Nationally and internationally the campaign garnered substantial positive media coverage[16] which assisted TAC to amplify stories of the human cost of denial of HIV medication to a national and international audience. The human right of access to treatment for HIV became a moral dilemma for society as a whole, including those who would normally ignore, dismiss – or be alienated by – the privations of the poor.

However, by framing profiteering as a rights violation and challenging it with reference to the South African constitution TAC made it an issue that ought also to have a legal remedy. This campaign (and future ones), therefore, revolved around setting out the duties of the South African government arising from their being tied to the human rights that are entrenched in the South African constitution.

These rights apply to a range of issues and are explicit, measurable and justiciable. For example:

- s 24 says people have a right “to have the environment protected”;
- s 25 says “The state must take reasonable legislative and other measures, within its available resources, to foster conditions which enable citizens to gain access to land on an equitable basis”;
- s 26 says “The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of.. the right to have access to adequate housing”;
- s 27 says “The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of”.. the rights to access to health care services, sufficient food and water, social security.”

Thus, in campaigns around the price of medicines TAC argued that the fact that the constitution creates a legal duty to fulfill certain human rights obligations (in this instance the right of access to health care services) dictates that the government take steps to overcome problems such as the affordability of medicine, especially when it has a legal means to do so. The legal means are the threat of compulsory licensing or parallel importation, legal measures the government had vigorously defended from both the pressures of the US government and pharmaceutical companies over South Africa's amended Medicines Act.

But in making claims for the right to a PMTCT programme (and subsequently in the demand for a national ARV treatment plan), TAC went further than just demanding that government comply with its legal obligations. It also worked with scientists and researchers to develop plans and alternative policy proposals which would fulfil the definitions of reasonableness that the Constitutional Court has said the government must comply with.^[17]

Consequently, what distinguishes TAC from other South African campaigns, such as for a People's Budget or Basic Income Grant (BIG), is that it can frame its policy alternatives not simply as 'better pro-poor policy' but as demands based on legal entitlement -- and therefore as positive duties that lie with national governments and, where relevant, the multinational corporations (MNCs) and multilateral institutions. To enforce these duties TAC has created the capacity to utilize a combination of negotiation, litigation and mobilization – sometimes simultaneously.^[18]

Some people will undoubtedly argue that such an approach will reveal its limitations when it comes up against defences based on arguments about resource constraints and “available resources”. However, in a system of governance in which rights are (or should be) pivotal to policy making, decisions on resource allocations must be subject to what the South African Chief Justice calls the “culture of justification”. This means that they must be determined by more than just what state treasuries (in their own wisdom) tell us is affordable. In countries such as South Africa that have embedded human rights in their legal systems it is *legally required* that there be transparency about the methods used to calculate ‘available resources’.^[19] Further, when faced with legitimate budgetary constraints that may limit rights then consideration should be given as to how some costs might be reduced (by, for example, licensing generic medicines) or further resources acquired (by taking over essential property or facilities).

The approach described above would be denounced by many on the left as reformism. ^[20] It differentiates TAC from social movements who have campaigned vociferously around socio-economic rights such as access to land or electricity, but stop short of engaging with governments on what a reasonable plan to provide for these rights would entail, because they do not believe that ‘under capitalism’ such a plan is possible.

But whilst TAC's agrees that the roots of much inequality are to be found within capitalism and aspects of the globalization of the world economy, it operates from the political conviction that significant reforms and policy shifts *can* be attained within the current econo-legal framework – but only if they are fought for and if they are linked a more refined and legally developed argument about the positive obligations of the state.^[21]

This is explored below.

The Redistributive Effects of TAC's Human Rights campaigns

After all that has been said above it seems an odd omission that TAC's constitution originally said nothing about human rights! Instead it describes its objectives as including to:

“Challenge by means of litigation, lobbying, advocacy and all forms of legitimate social mobilisation, any barrier or obstacle, including unfair discrimination, that limits access to treatment for HIV/AIDS in the private and public sector;”^[22]

However, in a discussion document adopted at its 2008 National Congress TAC defines its vision as being to support:

“the constitutional vision that every person is born with the inalienable rights to life, dignity, health, freedom and equality. In the context of the HIV/AIDS epidemic, the TAC aims to achieve universal access to prevention, treatment and care for all people living with HIV/AIDS and other illnesses.

Equality for women, the eradication of gender inequality and gender-based violence is indispensable to HIV prevention, treatment and care.

A single, equal, free-at-point of use, quality and adequately resourced public health service for all people is the right of every person and the duty of every state. Universal access to HIV/AIDS prevention, treatment and care requires the building of such a system without delay.”[23]

Achieving the vision above will not be possible without a significant shift of resources (or what Richardson calls a ‘wealth transfer’)[24] from both the state and the private business sector to poor people. To illustrate: successfully bringing down the price of medicines redistributes a value, that would otherwise have been claimed as profit by shareholders, to poor communities. Similarly, forcing a government to introduce a new health service, such as a PMTCT programme, requires an investment in infrastructure and human resources that might otherwise not take place. This is a net gain for poor people that goes beyond the direct benefit received by the people in need of treatment.

Analysing these wealth transfers provides another interesting way to assess the outcomes of TAC’s right to health campaign. Through price reductions, cost of care averted and increases in budgetary allocations it is possible to reveal the tangible benefits of a mobilization for human rights.

In the early 2000s the combined campaigns of TAC, and international NGOs such as Medecins Sans Frontieres and Oxfam, [25] put the pharmaceutical industry under a harsh spotlight that contributed to dropping prices. I am not aware of any analysis that has attempted to quantify the redistributive results of these campaigns, but below I attempt a rough calculation of the wealth transfers.[26]

Price reductions:

When TAC was founded in late 1998 the price of the traditional first-line regimen of anti-retroviral medicines (AZT, 3TC, NVP, DDI, D4T) was approximately R4500 per month. However, in the early 2000s the introduction of generic competition via ARV production in Brazil and Thailand, together with the international campaign that reached an apex when TAC caused the Pharmaceutical Manufacturers’ Association (PMA) to withdraw legal action against the South African government,[27] led these prices to begin to drop significantly. By 2007 the first line regimen cost less than R300 per month.

In early 2004 TAC’s legal challenge of excessive pricing via South Africa’s Competition Commission (launched in September 2002) led to seven voluntary licenses being issued to generic drug manufacturers, increasing supply and reducing cost.[28] The reduction in drug prices were a huge cost saving to the government by the time it launched its national ARV treatment programme.[29]

Similarly, in 2000 the anti-fungal Fluconazole, held under patent by Pfizer in South Africa, cost over R100 per pill. However, as a direct result of TAC’s threat of legal action in May 2000 Pfizer announced its Diflucan donation programme to the South African government. This programme was criticized harshly by TAC for its restrictiveness. Indeed even after the announcement of the donation TAC considered it necessary to launch its Christopher Moraka Defiance Campaign against Patent Abuse. [30] The pressure of the campaign and close monitoring of the Diflucan donation (TAC established a ‘Diflucan watch’) ensured that the donation became more extensive than would otherwise have been the case. This too was a significant cost saving to government, which estimated that over the course of the programme Pfizer would contribute more than \$50m worth of Diflucan.[31]

Finally, in a number of cases the mere threat of legal action by TAC and the ALP was enough to bring about a reduction in the price of several essential medicines for HIV-related opportunistic infections, including Amphotericin B.[32]

Costs of Care:

Linked to cost savings won for both the government and the private health sector on the price medicines (which have permitted much wider access), it should also be possible to calculate the costs of the need for care that has been averted as a

result of providing people with effective medicines. For example, through its successful mobilization and litigation to compel the government to have a reasonable programme to prevent mother to child HIV transmission TAC has saved the government the costs of medical care for tens of thousands of infants who might otherwise have been infected with HIV. The PMTCT programme has brought about the expansion of health infrastructures and services to poor people, constituting both a cost and cost saving to government.[33]

TAC had from the outset campaigned for a national anti-retroviral treatment programme for adults and children. Until August 2003 this met with fierce resistance from the South African government – a resistance which only buckled because of the pressure of TAC. But after 2004 South Africa established the fastest growing anti-retroviral treatment programme in the world. By early 2008, it was estimated that over 350,000 people were receiving treatment. However, as with the Diflucan programme TAC remained vigilant after the programme was started. Mobilisations, now targeting roll-out at a provincial and facility level, continued. In addition TAC helped to establish a network dedicated to monitoring and reporting on the ARV roll-out's progress.[34] This has made the programme the most closely monitored programme in South Africa, requiring the government to constantly account for its omissions and weaknesses.

As a result of this programme, at least 350,000 people are alive who would have died. From this it should be possible to calculate the costs of medical care averted, as well as the social and economic costs of orphan care averted as parents remain alive.

In addition to the above the TAC could claim as 'non-redistributive outcomes' of its human rights based campaigns, the high levels (so far) of adherence to anti-retroviral treatment by patients (compared particularly with TB where South African has a dismally low cure rate), and the injection of a new enthusiasm into certain levels of health delivery, as a result of increased resources and the ability of health care workers to actually improve their patients lives.

Increased Budgetary Allocations for HIV and Health:

As a result of the 'natural' pressure of the epidemic on the health system, but driven faster by activist demands, the allocation in the budget to health in general and HIV in particular has witnessed five years of expansion. In 2007 according to the Treasury:

“Spending on HIV and AIDS grew sharply from R618 million in 2003/04 to R2,4 billion in 2006/07 and is budgeted to grow to R3,9 billion by 2009/10.”

However, in the 2008 budget speech expenditure had been further revised upwards to R6.5 billion a year by 2010/11.[35] According to the budget review this:

“Additional funding should allow 500,000 more people access to treatment in addition to the 418,000 already on treatment, as well as increasing the numbers of people tested, and expanding a range of prevention programmes.”[36]

Most significantly of all, in 2007, the South African Cabinet endorsed the *National Strategic Plan on HIV, AIDS and STIs (2007-2011)* – known as the NSP - which contains a preliminary costing of R45 billion. This is significantly more than the Medium Term Budget Framework allocation of R14 billion between 2007 and 2009.

Although not widely known, the process of drafting the NSP was heavily influenced by TAC, which linked the finalization of an ambitious plan, to its willingness to trust and work with the government after the debacle caused by South Africa's Health Minister at the 2006 International AIDS conference in Toronto.[37] The plan contains the seeds of future human rights campaigns and sets an example by being the first programme to simultaneously model its costs, based on actual interventions, rather than to set interventions within predetermined costs. Whether, the South African state can be persuaded to fund this programme, is an as yet unwritten chapter of this history.

Developing a New Model for the Use of Law and Legal systems that Empowers the Disadvantaged

Throughout this chapter I have made a number of large assumptions about the rule and role of law: these include that there is a genuine separation of powers and that the executive will respect orders of the courts; that the courts themselves are politically impartial and genuinely abide by the dictates of the Constitution; and that human rights organizations are able to utilize the courts.

These assumptions may hold in South Africa, at this point in time. But, as was seen in Pakistan in late 2007, they are far from immutable. A social movement that makes a fetish of the rule of law is making a grave mistake. On the other hand a social movement that disavows human rights because they implicate law is making just as great a mistake. The ideas of the rule of law therefore require further analysis and elaboration.

In this and earlier chapters I have tried to show how combining human rights advocacy with litigation and legal argument about State's duties towards health, does (and can) bring about tangible improvements. But this begs another issue about access: it is well and good for a skilled social movement to use the law to the advantage of the poor, but can the poor replicate this approach in every day life?

In the next two chapters I look at South Africa's constitution and how it has been used – up to this point – to challenge discrimination against people with HIV and to promote and fulfill the right of access to treatment. But the bigger question is what does the Constitution, which embodies the legal system, require of the government in terms of improving access to itself; what of the systems that would make this a reality? I therefore now ask whether a similar argument about state duties in regard to health can and should be mounted in relation to legal systems.

ENDS

[1] L London, Health and Human Rights: What Can Ten Years of Democracy in South Africa Tell Us? *Health and Human Rights, An International Journal*, Vol 8 no 1, January 2006.

[2] Heywood, M. How the Poor Die: HIV/AIDS and Poverty in South Africa, *The African Communist, journal of the South African Communist Party*, No 153, 2000, 14-21. Heywood, M, Altman, D. Confronting AIDS: Human Rights, Law and Social Transformation, *Health and Human Rights*, Vol 5:1 2000, 149-179.

[3] The history of the TAC's campaigns is not the subject of this article. This can be found in several other sources. See for example: Friedman, S & Mottiar, S. Rewarding Engagement? The Treatment Action Campaign and the Politics of HIV/AIDS, A Case Study for the UKZN project entitled Globalisation, Marginalisation and New Social Movements in post-Apartheid South Africa, 2004; Heywood, M. Shaping, Making and Breaking the Law in the Campaign for a National HIV/AIDS Treatment Plan, in *Democratising Development, The Politics of Socio-Economic Rights in South Africa*, Martinus Nijhoff Publishers, 2005; N Natrass, *Mortal Combat, AIDS Denialism and the Struggle for Antiretrovirals in South Africa*, UKZN Press, 2007.

[4] B Loff and M Heywood, Patents on Drugs: Manufacturing Scarcity or Advancing Health, *Journal of Law, Medicine and Ethics*, 30 (2002): 621-631.

[5] M R Reich, Reshaping the State from Above, from Within, from Below: Implications for Public Health, *Social Science and Medicine*, 54 (2002) 1669-1675.

[6] Specifically in relation to HIV the concept was first utilized in the United States by groups such as the Gay Men's Health Crisis (GMHC), who in 1999 came to South Africa to provide training to the first cadre of TAC treatment literacy activists.

[7] See TAC, ALP, *HIV in Our Lives, A Book of Information Sheets for People Living with HIV, Support Groups and Clinics* (2003); TAC & ALP, *Pregnancy and HIV/AIDS*, 2003; TAC, *ARVs in Our Lives, A Handbook for People Living with HIV and treatment advocates in Support Groups, Clinics and Communities* (2006); *TB in Our Lives*, 2007; *HIV and Nutrition*, 2008. All are available at: www.tac.org.za

[8] This aspect of TAC's work is overlooked by researchers. And yet it is the largest part of TAC's apparatus. In 2007 over 200 people trained and deployed as treatment literacy practitioners throughout South Africa. According to TAC Chairperson Zackie Achmat, the TLPs reach over 100,000 people per month (see Chairperson's Report to TAC National Congress, 2008). It is also the largest part of TAC's budget, approximately \$1.5 million in 2007.

[9] For example, in interviews TAC volunteers are quoted as saying things such as "I am living because of TAC" "TAC puts self-esteem back into people" and "In TAC you are in a university. You learn and grow with knowledge." See, Boule, J and Avafia T, Evaluation of the TAC, June 2005, available at www.tac.org.za

[10] SA Constitution s 27(1)(b) . Despite this provision of the Constitution, there is still endemic malnutrition in South Africa and the right to sufficient food has not yet become the focus of social justice campaigns.

[11] C Allan, 'Social Accountability, Power, Corruption and Poverty', unpublished paper, June 2007. This paper provides a critique of both neo-liberal and determinist Marxist analyses of poverty, human rights and the state. However it makes the mistake of calling for recognition of 'a right to social accountability', rather than appreciating that social accountability is fundamental to a number of human rights that are already recognized, including access to information, just administrative action and access to courts.

[12] The right to food movement in India has certain similarities with TAC's approach. It too carries out rigorous research into and monitoring of starvation, which is then developed into concrete policy alternatives. Right to food organizations and activists, such as the People's Union for Civil Liberties, have also undertaken legal action that has resulted in far reaching judgments. Since 2001 the Indian Supreme Court has issued a series of orders interpreting the Indian Constitution in the light of the human right to food. The court orders address the systematic violations of this right in social programmes such as the Targeted Public Distribution System, Employment Guarantee and the Midday Meal Scheme for school children. (See, Centre for Equity Studies, *Commissioners to the Supreme Court on the Right to Food: A Brief Introduction*, undated). However, there are key differences. First of all 'hunger literacy' does not appear to exist or be seen as a means of mobilizing people. Secondly there might be an over-reliance on litigation, creating the impression that rather than using the law as just one prong of a strategy it has been separated from the day to day struggles of the hungry. Consequently, the campaigns have remained in the hands of a small number of lawyers leaving starving people invisible, and largely unorganized.

[13] See Heywood M. 'TAC's Focus on Anti-Retrovirals is Not Narrow', republished in *TAC Newsletter*, 5 May 2003: "To assert the right to life, to continue to breathe, is not "narrow". Unfortunately, the AIDS epidemic is a reality, and for many people in the late stages of HIV infection access to medicines determines whether or not that right is extinguished."

[14] See www.tac.org.za/treat.html

[15] At the time TAC was not aware that the real reason was the AIDS denialism of the President. In 2007 a series of articles were published providing evidence that President Mbeki's AIDS denialism originated during this time, initially linked to efforts by the ANC to finalise the development of a drug that it imagined would be a lucrative alternative to AZT. See: J Myburgh, 'The Virodene affair (I), The secret history of the ANC's response to the HIV/AIDS epidemic': <http://www.politicsweb.co.za/politicsweb/view/politicsweb/en/page71619?oid=83156&sn=Detail>

[16] In this campaign media reportage of avoidable infant infections pricked at the conscience of middle class people who are otherwise insulated from the pain of people with living with HIV. Contrary to pro-poor struggles that marginalize middle class people and consider their support redundant, TAC has actively solicited the involvement and engagement of this class of society – whilst holding firmly to positions of principle. Whilst TAC positions is an organization whose membership are overwhelmingly from the poor, and whilst it is on the 'left' of social policy, it has avoided presenting HIV crudely as 'class issue' in which all people with power or wealth are cast as enemies.

TAC's avoids espousing glib political dogmas which deny that far-reaching reforms are possible under capitalism, or without an impossible reverse of the processes of globalisation. This has contributed to a broad cross-class and cross-race support for all of TAC's campaigns, including breaking the law to import generic drugs in 2001, and civil disobedience against the ANC government in 2003. One result has been that multi-national pharmaceutical companies, with huge resources, fall prey not just to the accusations of a shard of AIDS activists, but became demonized across the whole spectrum of society – their conduct denounced in law, literature and science. Similarly, the pro-Mbeki ANC leadership, despite its huge reservoir of post liberation support and trust, failed with its multiple calumnies to depict TAC as an enemy of the ANC. For a recent article on the role of the media see, S Jacobs, K Johnson, 'Media, Social Movements, the State and HIV/AIDS in South Africa', *African Studies Quarterly* (forthcoming in 2008).

[17]

When coming to socio-economic rights the concept and definition of reasonableness has acquired great importance in South African jurisprudence. According to the Constitutional Court, reasonableness requires: xxx...

[18] Since 1999 TAC has undertaken major constitutional litigation on at least five occasions, including for a national programme to prevent mother to child HIV transmission (2001-2002); for access to the implementation plan for the

anti-retroviral roll out (2004); for access to ARV treatment for prisoners at Westville prison (2006-2007); to challenge the pricing structures of GlaxoSmithKline and Boehringer Ingelheim (2002); to defend the Medicines Act against charlatans such as Matthias Rath (2006-2008).

[19] Although I am not aware of jurisprudence stating as much it is clear that this is required by the Constitution. For example, the repeated mention of 'available resources' in the Constitution, must be connected to rights to access to information (s32), just administrative action (s33), and the section dealing with basic values and principles governing public administration (s195) which explicitly requires transparency, accountability and 'efficient, economic and effective' use of public resources.

[20] It is sad that in the hands of a number of social movements these issues sometimes appear to be more valuable as a whip to beat capitalism and the ANC, than a means to bring about measurable reform and improvements.

[21] See K Johnson, AIDS and the Politics of Rights in South Africa: A Contested Terrain, *Human Rights Review*, Vol 7:2, 2006; M Heywood, TAC and the Politics of Constitutionalism,

[22] Constitution of the TAC, as amended, December 2004.

[23] TAC, National Executive Document for Discussion and Proposed Congress Resolutions Based on Organisation Review Commission and Evaluation, 24 September 2007.

[24] H J Richardson III, Patrolling the Resource Transfer Frontier: Economic Rights and the South African Constitutional Court's Contributions to International Justice, *African Studies Quarterly, The Online Journal for African Studies*, Fall 2007.

[25] See: MSF's 'Access to Medicines' campaign, Oxfam's 'Cut the Cost' (www.maketradefair.com/en/). Organizations such as Health_Gap in the USA also have contributed greatly to raising awareness in developed countries of the iniquity of unaffordable medicines.

[26] TAC does not claim sole credit for these outcomes. However, either via litigation or mobilization or both it provided the initial impetus for each of these breakthroughs and then sustained pressure to ensure their implementation.

[27] See TAC Newsletter, 24 April 2001, www.tac.org.za/newsletter/2001/ns010424.txt

[28] See: TAC Newsletter, 10 December 2003 'Competition Agreements Secure Access to Life-saving Affordable Medicines', www.tac.org.za/newsletter/2003/ns10_12_2003.htm

[29] See Heywood: "Debunking 'Conglomo-talk': A Case Study of the *Amicus Curiae* as an Instrument for Advocacy, Investigation and Mobilisation" *Law, Democracy and Development*, 2002; ALP, "The Price of Life – Hazel Tau and Others v GlaxoSmithKline and Boehringer Ingelheim: a report on the excessive pricing complaint to South Africa's Competition Commission", available online at <http://www.alp.org.za/modules.php?op=modload&name=News&file=article&sid=222>; and MSF www.accessmed-msf.org

[30] See TAC Newsletter www.tac.org.za/newsletter/2000/ns001017.txt

[31] Department of Health Press Statement, 'South African Ministry of Health and Pfizer Initiate Diflucan Partnership Programme', 1 December 2000.

[32] J Berger (presentation to SA HIV Clinicians Society)

[33] See Heywood, M. Preventing Mother to Child HIV Transmission in South Africa: Background, Strategies and Outcomes of the TAC case against the Minister of Health, *South African Journal on Human Rights*, Vol 19 part 2, 2003. In March 2007 the SA government issued a media statement claiming that "More than 80% of government clinics are currently providing prevention of mother to child transmission of HIV service and the target is to have these services available in all clinics by December 2007" The statement added that "3 382 out of 3 663 primary health care facilities (clinics) were offering the service. "This represents 83% of public health clinics." "At least 580 880 pregnant women accessed the PMTCT services during the calendar year 2006. Of these, 74 052 antenatal clients received Nevirapine prophylaxis. A total of 19 758 babies born to mothers living with HIV were tested for HIV infection. 16 288 babies tested HIV-negative while 3 470 babies tested HIV-positive."

[34] See Joint Civil Society Monitoring Forum (JCSMF) at www.jcsmf.org.za

[35] Budget Speech for 2008, 20 February 2008.

[36] See National Treasury, Intergovernmental Fiscal Review, 2007, Provincial Budgets and Expenditure Review, 2003/04 – 2000/10, Chapter 3, Health pp 45-47 available at: www.treasury.gov.za/publications/igfr/2007/prov/default.aspx .

[37] See M Heywood, The End of Politics in ALP 2006/7 Annual Review available at www.alp.org.za

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