The Human Right to Health and Primary Health Care (PHC) Policies

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1. INTRODUCTION

Due to its position between legal systems, politics, socio-economic conditions and the health sector, the human right to health has to accommodate, among others, institutions and persons commissioned and dedicated to healthcare. This necessary »structural coupling« of different functional systems (in the sense of Luhmann's social theory)[1] may cause friction in the competition for supremacy as well as giving rise to synergies and thus co-operation in pursuing common goals. Even agencies and experts in the health sector do not speak with a single voice, since bodies such as the WHO on the one hand and the World Medical Association (WMA) on the other, or professional groups such as public health officials and medical doctors, are especially and deeply divided on several issues pertaining to the right to health. Low-cost care vs. professionalism, prevention vs. cure and public vs. private organization of services are some of the most important lines of conflict between the various interests. These multiple conflicts became especially evident in the debates around the WHO policy of Primary Health Care (PHC) adopted in 1978 at the international conference of the WHO und UNICEF at Alma-Ata, now Almaty, in Kazakhstan. The aim of this new strategy was to improve the health of all human beings

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[1] Meyer et al. (2015), 349–351.

worldwide by concentrating on essential areas, favouring prevention and those curative interventions where importance and effectiveness were well known. Thus its elements, listed in the order of their supposed impact, were health education, water and sanitation, nutrition, vaccination, mother and child health services, control of the most common diseases and basic treatment of common conditions.

Although intended as a new approach for the whole world, PHC became a policy especially for Low Income Countries (LICs) and less privileged regions and groups in Middle Income Countries (MICs). PHC did not change the health policies of industrialized countries in either the West or the East. Powerful groups in market economies in the West felt their approach of consumer-friendly healthcare provision to be superior where resources were sufficient, and official socialism in the East claimed to have already implemented the program for a long time. Therefore the most important institutional context for PHC turned out to be development cooperation and health planning in the countries receiving »development aid«. Among those countries where PHC became the official health policy for the whole (biomedical)[2] healthcare system were even some of the failing or already failed states of Africa. Thus the standards of many Upper Mid-Income Countries (UMICs), like the BRICS states (Brazil, Russia, India, China, and South Africa), where civil society organizations and sometimes even individuals go to court to claim the right to health, do not concern the situation PHC was most vigorously applied to. This uneven pattern of health policies in the Global South requires that any examination of PHC needs to integrate not only a strong public health and partly medical perspective into the debate on the right to health, but also that of LICs, especially the formerly so-called *Least Developed Countries* (LDCs).

Such an introduction of the perspective of healthcare policies into the discourse on the human right to health means reversing the common approach of activism, i.e. the legal or moral way of looking at the questions: Not only does the human right to health inform health policy, but this also applies the other way round, i.e. health policy informs human rights poli-

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2 Although the author has also extensively worked on so called ›Traditional Medicine‹ this contribution focusses for various reasons the science-based type of medicine developed in 19th century Europe and globalized since then, simplifying called ›biomedicine‹; cf. Bruchhausen (2011).

cies. Such a shift can serve three important aspects: It may explain a certain common uneasiness among health experts and within health policy concerning the human right to health; it can help to overcome this unsatisfactory divide; and it demonstrates the previous as well as the current role played by human rights language within and regarding healthcare in LICs. All these issues primarily concern empirical questions of practicability and usefulness in pursuing common aims rather than normative or theoretical debates. The theoretical discussion on the »conceptional soundness« of human rights, »in particular the so-called economic and social rights, or welfare rights« or »second generation rights«, is therefore rarely touched upon in this contribution.[3] But theoretical implications cannot be avoided completely, e.g. when looking at the relationship between social and individual aspects of health. Such a distinction between an individualizing and a socially integrating understanding of claims is also a frequent issue in other areas of human rights. In the present paper, however, there will be no discussion of a fundamental clash between the individual and the social dimension, as human rights are – following Amartya Sen – understood here as »pronouncements in social ethics«.[4]

2. HUMAN RIGHTS AND PHC – AN ISSUE AT ALL?

Just looking into the official documents seems to render the topic of tensions between the right to health and PHC a »non-issue«. Neither of the authoritative texts – the Declaration of Alma-Ata in 1978 and the previous resolution on »Health for All by the Year 2000« of the World Health Assembly (WHA) in 1977[5], which together form the foundation of PHC as an official policy of the WHO – lacks clarity of expression in this regard: The first article of the declaration »strongly« reaffirms that health, in the definition of the WHO constitution's preamble, »is a fundamental human right«, in the introducing participle clauses the second declared motivation behind the WHA resolution states it to be »a basic human right«.

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[3] Sen (2004), 316.

[4] Ibid., 355.

[5] Res. WHA30.43, 19 May 1977.

Thus from this official point of view the case is clear: PHC is based on the human right to health, and PHC strives to fulfil what this right requires. Yet there were already certain occurrences during the conference of Alma-Ata that may cast doubt on the perception of a completely easy relationship between the two:

1. The accompanying WHO program was called »health for all«, no longer health for everyone, as the Preamble of the WHO constitution of 1946 would have wished and the Norwegian co-founder of WHO Karl Evang had formulated in his retrospective dating from 1973.[6] The reasons do not seem to be merely linguistic.
2. As medical historian Michael Knipper has established, Director-General Halfdan Mahler had the term »human right« in the manuscript for his speech in Alma-Ata but left it out in the spoken version.[7] Therefore it is missing in the protocol. We can only speculate whether this omission stemmed from the strategic consideration of avoiding resistance or from other reasons.
3. Backstage, conflicts between an individualistic and a collectivistic understanding of rights and duties persisted between the US and Soviet delegations in particular. These conflicts left traces in the declaration, e.g. when the only other use of the word »right« in the whole declaration said in Article IV: »The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.« Combining right and duty in this manner indicates a certain uneasiness with an exclusive reference to a right.
4. The human right to health itself was not an explicit point of discussion at the conference. It seems to have entered the first article undebated, just from the preamble of the WHO's already accepted constitution. The conclusion regarding PHC put forward by Alison Lakin in a British dissertation in 2001 is that »the approach was developed without any consideration of human rights.«[8] And two lawyers, US-American Benjamin Mason Meier and the former WHO legal advisor, now UK-based African scholar William Onzivu, saw in 2013 a »failed effort to employ

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[6] Evang (1973).

[7] Personal communication on unpublished research.

[8] Lakin (2010), 10.

rights-based language for primary health care«.[9] There is no reference to PHC in the short version of the WHO genealogy of the human right to health.[10]

5. The first article of the Alma-Ata Declaration, quoted in part above, continues – similar to the resolution of 1977: »and that the attainment of the highest possible level of health is a most important world-wide social goal.« By the very wording, the »attainment of the highest possible level of health« is no longer a human right itself, unlike as stated in the International Covenant on Economic, Social and Cultural Rights of 1966,[11] but »a most important world-wide social goal«. This is a very telling shift or difference, and the possible underlying tensions and their solution will be the central question of this paper.

What the paper does not want to discuss in detail are two further areas that might also be expected, i.e. the role of human rights other than the right to health, especially civil and political rights, in the field of health. The question as to how such rights may be limited by public health considerations is already specifically dealt with in the Siracusa principles 25 and 26 of 1985.[12] And the opposite question regarding how civil and political human rights guide and limit the action of healthcare providers touches on much of the enormous field of professional, biomedical and clinical ethics and cannot therefore be tackled here. The paper will confine itself to the right to

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[9] Meier/Onzivu (2013).

[10] WHO (2015); it is only briefly mentioned in the 51 pages of the complete fact sheet.

[11] ICESCR, Article 12.

[12] E/CN.4/1985/4, 28 September 1984: (besides the areas »law«, »democracy«, »public order«, »public morals« etc.) »*iv. public health*

25. Public health may be invoked as a reason for limiting certain rights in order to allow a state to take measures dealing with a serious threat to the health of the population or individual members of the population. These measures must be specifically aimed at preventing disease or injury or providing care for the sick and injured.

26. Due regard shall be had to the international health regulations of the World Health Organization.«

health itself, without ignoring its necessary place in the net or fabric of all human rights, or to put it another way: the indivisibility of rights.

3. THE AMBIGUITY AND DECLINE OF THE HUMAN RIGHT TO HEALTH IN WHO

An ambiguous position towards the right to health is not only characteristic of Alma-Ata, but is part of the whole history of the WHO up to about the year 2000. Even in the constitution of the WHO of 1946, there was already tension between an individual and a collective understanding: Showing an ambivalence between »human right« and »social goal« similar to that evident in the later WHA resolution of 1977 and the Declaration of Alma-Ata, the preamble of the WHO constitution spoke of a right of »every human being« whereas its Article 1 referred to an »attainment by all peoples« as the objective. Since many – wrongly, as current majority opinion says – regarded the articles of the constitution as the only binding part and the preamble with its principles as a mere declaration of good will, there was not much resistance against the later focus on peoples rather than on individual people.

The ensuing development of WHO activities clearly favoured the health of populations over that of each individual. Eradication campaigns against malaria, yaws or polio dominated when compared to individual care. The growing Cold War and a new Director-General supported this change. Between the options of policy-setting and operational activities, the WHO moved – incentivised by additional funds for such work by the UN Extended Program on Technical Assistance (EPTA) and by earmarked funding from individual member countries as well as on request of receiving member countries – to the latter, i.e. to field operations in the control of single diseases.[13] In 1963, even a legal advisor to the WHO expressed it as follows:

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[13] van Zile Hyde (1953).

»a programme based on the notion of priorities has given way to one based on the needs of the countries themselves, expressed through their requests for advice and assistance.«[14]

The WHO was transformed from what had been a partly political agency into a mostly technical one. It therefore withdrew its co-operation from the 1966 International Covenant on Economic, Social and Cultural Rights and – as seen – paid only lip-service to the right to health in its declaration on PHC in 1978. Meier has demonstrated this in much detail with new historical evidence and argues therefore that the WHO became apolitical.[15] According to Meier, it was the HIV/AIDS activism of Jonathan Mann that reintroduced a major political and human rights perspective into WHO work.

4. POLITICAL VS. TECHNICAL OR INDIVIDUAL-VS. POPULATION-CENTERED POLICIES?

Meier's two major hypotheses, first, that the WHO was turned from a political into a technical agency in the 1950s and why this was so, and second, that the practice of PHC is notorious for not incorporating a human rights approach, are certainly correct.[16] His claim, however, that the former is the main cause or even the only explanation for the latter has to be doubted profoundly. Several of the debates on the tensions between an individual

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[14] Gutteridge (1963).

[15] Meier (2010).

[16] Meier's attempt to contrast the normative and the factual is not convincing. In his argument that – without practical success – the WHO intended a return to a human rights base, Meier (2010) saw in the »Health for All« strategy of the WHA und WHO (that both rather avoided the language of rights) a »rights-based policy«. For this argument, he uses a series of re-interpretations of paragraphs that is not backed by the document of Alma-Ata itself. The right to health is mentioned a single time only, in the first paragraph, but Meier calls the eight elements of PHC listed in para. VII »rights-based government obligations« (ibid., 178), turns the definition of PHC into a »collective right« to health care (ibid., 177) and maintains – referring to MacDonald – that Alma-Ata put »public health under the aegis of the right to health« (ibid., 178).

right and very limited resources provide a better explanation than this alleged causality. The optimism around 1950 that science would soon enable the world to grant all human beings maximum health had disappeared by the early 1970s. The apparent victory over infectious diseases prompted health experts to look at other problems. The already mentioned physician and health politician Dr. Karl Evang wrote in the WHO Journal in 1973 that the greatest limitations in health are no longer the lack of scientific knowledge:

> »Now we have reached the point where the limiting factor is not knowledge but resources. Even the richest countries cannot offer optimum health services to individuals and communities in prevention, cure and rehabilitation in the combined field of somatic, mental and social disease. We are faced with the unpleasant, for psychological as well as political reasons perhaps insurmountable, task of stating priorities which would automatically exclude certain types of patients from an optimum type of service.«[17]

This tension between individual claims and limited resources extends well into the recent debates on the relationship between the human right to health and public health ethics.[18] These debates have often taken the form of a basic conflict between a purely individualistic (mis)understanding and a social or collective perspective on health – the well-known conflict that has to be overcome in other areas of human rights as well. Considering this conflict, the simplistic attribution of roles alleged by Meier and others that the later WHO was more technical and the view of the individual human right to health was more political can even be partially reversed: An individualistic view of health tends to technical solutions of biomedicine such as treatment and secondary prevention whereas a collective understanding of health favours political decisions on social measures such as the improvement of housing, nutrition, water supply, sanitation and education.

Evang saw the new challenges in »man-made pathogenic agents«, and the resulting long list includes cardio-vascular diseases, road traffic accidents, »dependence-producing drugs«, environmental pollution and urbanization with »muscular immobilization and various forms of social maladap-

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[17] Evang (1973), 6.

[18] Nixon/Foreman (2008); Steinmetz-Wood (2014).

tation«, »population explosion« and even infectious diseases by the reference to »venereal disease«.[19] The present UN concern for »non-communicable diseases« on a global scale was already previewed in the early 1970s, but did not receive much attention at that time.

The common fundamental conflicts between individual rights and social interests are more than obvious in the case of health:

- Individual rights demand e.g. freedom from coercion (such as quarantine, isolation or compulsory vaccination), even very expensive medical care and protection if urgently needed, and protection or care even for »unproductive« individuals (the unborn/children, disabled, retired, care-dependent).
- Crude social interest, however, would want collective protection against infectious individuals, cost-efficient healthcare for as many as possible and the survival of economically productive individuals only. Compared to this, public health with an egalitarian understanding is already more normatively charged than pure common interest as it also has obligations towards the health of the unproductive members of society. In a utilitarian understanding, however, it would value the health interests of the vast majority more highly than those of individuals or minorities.

Precisely these debates were the background when PHC was developed in the early 1970s: development workers and public health experts, especially in the Christian Medical Commission (CMC) of the World Council of Churches (WCC) in Geneva,[20] protested against the dominant position of the hospital and the medical profession, which favoured expensive care for individuals rather than more cost-efficient and socially just preventive medicine and »medicine des masses« (mass medicine). Although many doctors and nurses feared that the new focus on prevention and low-cost treatment would disadvantage patients in need of hospital care (and were proven to be right), most Northern and Southern governments and NGOs followed the new paradigm of PHC in their development policies. Forcing the governments of some »developing countries« to give up their preference for hospitals in the cities in favour of preventive and rural healthcare was highly po-

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[19] Evang (1973), 6.

[20] Taylor (1969).

litical. This political decision, however, was rather justified by social justice or national interest and not by the human right to health.

This ambiguity had continued in the WHO, e.g. when the 1977 resolution of the WHA reaffirmed the declaration of the WHO constitution that »health is a basic human right and a worldwide social goal«.[21] Today, the WHO still seems to be cautious: As late as 2013 it treated in a discussion paper the human right to health and health equity as separate goals.[22] This hints at their necessarily complementary character rather than subsuming one under the other.

Thus the debates on the relationship between the rights approach and public health, between individualistic and collectivist views, stem from the profound fears and mistrust developed among proponents of public health and PHC. Many of the provisions in the authoritative General Comment (GC) No. 14 of the UN Committee on Economic, Social and Cultural Rights (CESCR) of 2000, i.e. after the end of the East-West-conflict, reflect these fears. The principle of »progressive realization« and the attempt to limit it by »minimum core« obligations are all expressions of these tensions.[23]

5. HOW THE HUMAN RIGHT TO HEALTH INFRINGES PHC IN THE ALLOCATION OF SCARCE RESOURCES

I will now discuss three necessary restrictions to unquestioned advocacy of the right to health from a PHC perspective, starting each time from personal experiences or involvements and concerning different levels of decision-making. Two of the examples started years before GC No. 14, one even after. The background to this perspective is formed by philosophical and theological healthcare ethics, medical work and responsibility for a health district in Rwanda in the 1990s, field research in medical anthropology in East Africa in the 2000s as well as teaching and research on global health since 2009. A medical and empirical perspective of this kind is certainly different

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[21] Res. WHA30.43, 19 May 1977.

[22] WHO (2013), 2.

[23] Forman et al. (2013).

from that of human rights work in legal or political action. It has the intention of informing the latter since the empirical dimension needs to be respected in normative approaches more than has been the case to date.

5.1 The Privileged Urban Elite vs. the Rural Poor: The Responsibility of National Governments

The following example illustrates how a right to healthcare accessible only to a privileged few might even infringe on the health of many others. I remember a young patient in our hospital in Rwanda in 1995 who had a heart condition that required life-saving open heart surgery. This could not be done in the country, and I inquired into chances for surgery abroad. I was told by the Rwandese hospital staff that there was a passage in the law guaranteeing the right to all necessary medical care even abroad – but that only politicians and higher civil servants had so far got this opportunity for expensive treatment in Nairobi or South Africa paid by the Ministry of Health. Thus the right to maximum care, in this case at the price of several ten thousand dollars, clearly drew on resources that were urgently needed for quite basic healthcare for the rural population, where people died every day because some cents for transport, medicines or vaccines were lacking.

This is a major reason why public health experts and PHC protagonists before GC No. 14 refrained from always unambiguously emphasizing the right to medical care or health. They wanted it to be applied for the benefit of as many disadvantaged people as possible, not as a further possible privilege for those already better off. And as my story shows, this risk was and remains very real. GC No. 14 therefore needed to emphasize non-discrimination.[24]

This risk is especially great in highly centralized states with low civil society control of the government and with weak legal systems. Thus, contrary to the former Soviet claim at and after the conference of Alma-Ata that only a tightly state controlled system could guarantee the right to health,[25] it seems to be clear that decentralization and the strengthening of civil society are preconditions for the implementation of rather than the misuse of an (individual) right to health. The declaration of Alma-Ata had

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[24] E/C.12/2000/4, 11 August 2000, paras. 12, 18 and 19.

[25] Venediktov (1998).

acknowledged this in its principles of community participation. And GC No. 14 therefore also made this requirement explicit when it mentioned »in particular, participation in political decisions relating to the right to health taken at both the community and national levels«.[26] Legislation and jurisdiction alone are not sufficient to safeguard the right to health against misuses. The importance of monitoring is paramount. Several civil and political rights must be implemented as well, otherwise justifying a particular treatment by referring to the right to health could diminish health equity instead of promoting it.

5.2 The Bread Earners vs. the »Unproductive«: Options for International Donors

The second, somehow similar conflict of interests that I personally observed arose in the late 1990s in the context of the availability of antiretroviral therapy (ART) against HIV/AIDS. Initially in sub-Saharan Africa, the men who were affected above average by AIDS were those who had money, who could afford more women than others: the rich, those in public service like teachers, and thus the more articulate and powerful. Their mass dying, their loss was rightly regarded as a threat to the socioeconomic development achieved up to that point, and this prompted economically motivated international concern. Later, the even higher burden for women and the poor became obvious. Withholding possible ART for AIDS patients was then seen as a violating the human right to health.[27] Therefore there was a widespread fear among PHC adherents that a massive diversion of funds from established and urgently needed programs such as mother and child health or vaccination services in favour of fighting and treating AIDS would deprive the most vulnerable of already achieved standards of healthcare.

The only solution to this threat was that all the resources for AIDS programmes had to come from additional, new sources, and should not be taken from existing PHC programmes. This did not seem likely to many, as the consistent message of the neoliberal approaches since the 1980s with their enormous cuts in health budget by the Structural Adjustment Pro-

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[26] E/C.12/2000/4, 11 August 2000, para. 17.

[27] Stemple (2008).

grams (SAPs) had been that more funding for health was out of the question.[28] Two unexpected developments prevented the AIDS programmes from squeezing out other health programs: the production and use of ART medicines without license (especially through the courage of South Africa as a major user and India as a producer) and the enormous external funding for these drugs. We do not know what would have happened without the astonishing, unprecedented extra donations by governments and »philanthropocapitalists« like Bill Gates, which were certainly facilitated by the new economic approach to health in the World Bank and WHO reports.

The condition that resources for countering such new »violations« of the right to health must be additional to existing PHC funding should be the consequence of this example. This corresponds with the concept of the minimum core obligations which demands some basic health services in any case and with General Comment No. 3 of 1990 (GC No. 3) which already stated that »even in times of severe resource constraints […] the vulnerable members of society can and indeed must be protected by the adoption of relatively low-cost targeted programmes.«[29]

5.3 Lifestyle vs. Living Conditions: NCDs vs. Communicable Diseases in Current UN Programmes

The third example showing necessary precautions against the unwanted effects of an isolated implementation of the right to health concerns the recent shift of international attention to non-communicable diseases (NCDs), i.e. cardiovascular and respiratory diseases, diabetes and cancer. This new initiative is located at UN level as well as at the WHO and is contained in the Sustainable Development Goals (SDGs) as 3.4: »By 2030 reduce by one-third premature mortality from non-communicable diseases (NCDs) through prevention and treatment […]«. The hitherto common combination of prevention and best therapy in WHO programmes, e.g. for malaria (bed-nets and the medication co-artem), HIV/AIDS (safe sex and ART) and worms (sanitation and pharmaceutical de-worming), would be disastrous

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[28] Turshen (1999).

[29] E/1991/23, 14 December 1990, para. 12, referred to also in E/C.12/2000/4, 11 August 2000, para. 18.

for the resources of most healthcare systems in the case of NCDs. The assessment of the increasing problem is certainly correct. The rise of these diseases, which are often or mostly life-style related – caused by too much sugar, fat, salt or harmful substances like tobacco and alcohol, low intake of fibres or vitamins and lack of physical exercise – and a decrease in several infectious diseases caused by poor living conditions has been almost universally observed, notably more in MICs than in LICs. Yet again, if the right to health and its therapeutic requirements were applied to NCDs without any conditionality, a further threat to health equity could arise. I vividly remember the question posed by an expert in international health when the NCDs concept was presented: »Does it mean that Siemens [the German manufacturer of radiography equipment] can now approach the BMZ [German Ministry for Economic Cooperation and Development] demanding that equipment for heart catheterization has to be supplied all over the world?« The question, of course, was polemical, and the NCDs programme was clearly aimed at prevention, as increasing treatment of NCDs was precisely seen as overburdening most healthcare systems. But the fear and the danger are obvious: Treating all common life-saving therapies alike as would be required by an undifferentiated human right to medical care would be the end of PHC and the striving for more health equity. Considerations of comparative costs and equity cannot be excluded. The prioritization of cheap or cost-effective measures is an indispensable constituent of PHC. This is reflected in the warning in GC No. 14:

> »investments should not disproportionately favour expensive curative health services which are often accessible only to a small, privileged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population.«[30]

Nevertheless, it has to be admitted that some cost-effective preventive and curative measures, especially those requiring access to biomedical services, might still benefit the better-off more than the already marginalized and thus further increase health inequity.[31]

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[30] E/C.12/2000/4, 11 August 2000, para. 19.

[31] Schmidt/Barnhill (2015).

6. THE RECONCILIATION OF PHC AND THE HUMAN RIGHT TO HEALTH

It is obvious that PHC today can take account of human rights approaches more than ever before. But it is also true that there were historically contingent as well as argumentatively plausible reasons for cautioning against an insufficiently reflected and undifferentiated incorporation of the right to health into policies and laws before GC No. 14 in 2000. Even after this watershed in the history of the right to health, the scarcity of resources remains the major constraint. The social and economic realities cannot be excluded in normative discourses. The question remains one of distributive justice or equity, not primarily of law. For many decades it has been discussed under this heading of justice within the context of ethics – including biomedical and public health ethics – as a question of allocation which cannot simply be solved by referring to equal rights. Unlike civil and political rights, where fulfilling the rights of one group does not for the most part violate and often even promotes the same rights of others, completely fulfilling the right to healthcare for one group of patients may principally diminish the enjoyment of this very right for others quite substantially. The statement of the WHO constitution's preamble in 1946 that the »achievement of any State in the promotion and protection of health is of value to all« may be true for the preventive aspects but it is certainly not so for medical care where the level of treatment in the richest countries depends on economic means and on staff lacking in others. The »brain drain« of health workers into stronger national economies has caused a human resources crisis that the WHO has described as one of the major global health problems.[32] And some types of highly sophisticated treatment demand financial means that are increasingly far from imaginable in terms of global availability: Certain cancer therapies cost more per year than many people in the world earn during their whole lives – and in countries like the USA half of the population will be diagnosed with cancer during their lives.[33] Clearly some health achievements are not of value to all states.

GC No. 14 is proof that a reconciliation of individual and collective interest in healthcare can be attempted. The greatest part of its content is ob-

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[32] WHO (2006), 8–12.

[33] Lochlann Jain (2013), I.

viously a result of PHC experiences and thus of Alma-Ata. For someone familiar with PHC since the late 1980s, the five core obligations and the AAAQ (Availability, Accessibility, Acceptability and Quality) approach are just an extension of what Alma Ata already aimed at under the framework of health policy. Instead of complaining that PHC did not take up the right to health, one could also argue the other way round - that before GC No. 14 the rights approach was not sufficiently mature for PHC and that it needed these two decades as a learning process.

The human rights discourse is not the only one relevant to health for all. Quite similar discussions on negotiating individual and social interest were and are found in many other disciplines. It is a question of more and new interdisciplinary cooperation. In a similar way, the diverse processes of mainstreaming in health attempt to reconcile access for the hitherto disadvantaged with majority perspectives. Think tanks with advisory functions in drawing up the SDGs of 2015 demanded fewer top-down and fewer hierarchical approaches, favouring »Multi-stakeholder decision-making processes«[34] instead. The future will show whether this can be realized for health or whether we will have a struggle for power between the WHO fighting for governing global health and the UN claiming supremacy for rights issues. The last years have demonstrated that human rights are a powerful contribution to health for all if interpreted and applied in the spirit of PHC. But if used in the highly individualistic and legalistic way feared in the USA (where e.g. the enormous sums for compensation for malpractice threaten obstetric coverage), they could actually embody the enemy PHC was set out to fight at its very beginning.

7. HUMAN RIGHTS LANGUAGE AND ITS IMPACT IN OR ON PHC IN »LEAST DEVELOPED COUNTRIES«

The human right to health is mentioned more often in programmes from the Global North, e.g. of development co-operation, than in the countries that have the most pressing health problems. It appears as self-commitment on the part of donor countries or aid organizations and as a moral or political

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[34] Independent Research Forum (2013), 2.

appeal rather than in legislation. In such Northern programmes, human rights language is clearly invoked against specific and generally undesirable developments:

- The Humanitarian Charter of 1998 and the ongoing Sphere Project, a joint initiative of the major players in humanitarian assistance, referred to human rights in the case of humanitarian emergency aid (including PHC) – mostly without emphasizing a special human right to health – in order to avoid unprofessional philanthropy as well as undue foreign political interest.[35] The quality and quantity of humanitarian aid has to be based on the rights of the individuals, not on the preferences or even arbitrary decisions of the donors or providers, which might be influenced by the favouring of certain groups, countries or measures to others. The main references for the right to health are Jonathan Mann's reader of 1999,[36] GC No. 14 of 2000 and a WHO »Questions and Answers« of 2002,[37] but the scope of the Charter und the Sphere Project is purposely confined to emergency situations. The double character of rights between social appeal and law is clearly reflected in the second edition of the Sphere handbook: »The Charter is based on both ethical and legal foundations and refers to ›moral and legal rights‹.«[38]
- The German Government and its Federal Ministry for Economic Cooperation and Development have in various documents explicitly based their development policy in health on the human right to health, e.g. in a publication on health and human rights of 2009,[39] in the sector paper for development policies on health a month later[40] and in the global health policy paper of 2013.[41] The aim here is to support the long-standing major focus on strengthening health systems against purely economic

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[35] Sphere Project (2011); in the text, the right to health is explicitly mentioned on pages 83 and 291 only, in the bibliography pages 348 and 351.

[36] Mann et al. (1999).

[37] WHO (2002).

[38] Sphere Project (2012), 3.

[39] Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung (2009a).

[40] Ibid., (2009b) 4, 7–8 and 20–23.

[41] Bundesregierung (2013), 2 and 19.

arguments and against the dominance of vertical health programmes. The reference to the right to health has become an important argument in German development politics, with the purpose of avoiding inappropriate approaches of the past, i.e. the focus on foreign political interest so dominant in the 1950s and 1960s, on social utility in the 1970s, on austerity in the 1980s, on economic gain in the 1990s and on the feasibility of campaigns in the 2000s.

- In the advocacy by NGOs for health equity, promoted in Germany by *medico international* and the *Aktionsbündnis gegen AIDS* in particular, the human right to health has a very prominent place in the titles of actions and publications.[42] It is, however, above all a strong moral appeal to politics and individual conscience that is addressed in these uses of the word »right«, not a legally binding framework. Legal action by civil society organizations in partner countries is supported against both governments and companies, but has not usually been attempted to date by German NGOs in German courts for populations abroad.

The major field where the right to health is invoked for people living in countries of the Global North is that of the legal restrictions in healthcare for refugees and asylum-seekers. Withholding necessary treatment for those with a limited period of residence is interpreted as »human rights violation«.[43]

In comparison, the right to health is not or is just rarely mentioned in the health policies and debates in LDCs/LICs in Africa and by Africans. This at least is the impression gained from publications and from my own experience at a series of conferences on healthcare in Eastern, Southern, Central and West African capitals, including a session with the high court of Mali. African states and governments would be the first address to which claims to the right to health would be directed. It therefore seems that these institutions are not interested in raising this issue themselves. If civil society and its media are rather weak, a major debate on the right to health will be unlikely. In the more democratic of the BRICS states, by contrast, civil society organizations such as the Treatment Action Campaign in South Af-

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[42] Medico (2013); Aktionsbündnis gegen AIDS (2016).

[43] Ärzte der Welt (2015); Mylius (2016).

rica are able to force the government into a public debate and some initiatives.

There are several international initiatives that promise to considerably improve the attainment of health in LICs, such as Universal Health Coverage (UHC), which is also part of the SDGs. These initiatives are certainly strengthened by being able to refer to and apply the right to health. However, doubts remain as to whether the legal framework of human rights will be the most important contribution to better health or health for all over the next few years, at least in those places where improvement is most needed and would be the greatest. Even the current concept of the human right to health, i.e. that of GC No. 14, cannot replace relevant policies, but can only inform some important aspects of these that derive from a common learning experience over the last decades.

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