



Commodity vs. Right: Global health and the “pathologies of power”

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Thirty years ago in Alma Ata - the capital city of the republic of Kazakhstan- the [Declaration of Alma Ata](#) (DAA) urged governments, international funding agencies and organizations, and all health and development workers to protect and promote health for all. The DAA strongly reaffirmed that health “is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal.” Nonetheless, today the health of two-thirds of the planet’s population has deteriorated since then. One might ask, why? The answer lies within the political structure of our global system. The system- guided by the ideology of disempowering the vulnerable and the marginalized- gives way to top-heavy economic growth and looks after the interests of transnational corporations that institute the will of the few global financial institutions.

Thirty years after its publication, the DAA’s principles still possess convincing arguments for the importance of ‘health for all’ through community-based primary health care systems. Its visionary qualities present the potential genesis of ‘health for all’ to fulfill the human rights doctrine, since it incorporates and underscores the relevance of socio-economic and political factors and unequal development. The DAA’s principals also acknowledge the cyclical crisis of health care systems world-wide, particularly in Third World countries. Yet despite the polemical dimension of the DAA, its principles have been ignored by the market-based global economy.

The DAA asserted that the right to health is a fundamental constituent of the human rights’ agenda; therefore, its achievement required a comprehensive approach to societal infirmity. The political practices that put economic growth before human needs to achieve ‘evenhanded’ development were a complete breakdown not only for Third World societies, but for marginalized groups in the economically advanced world as well. As the DAA averred in 1978, the health attainment for all is required to achieve “sustained economic and social

development.” The DAA had foreseen that attaining “health for all” not only would sustain development, but would also “contribute to a better quality of life and to world peace.” According to the World Health Organization (WHO), health encompasses “a state of complete physical, mental and social well being”. Nevertheless, today we know that over 83% of the 6.8 billion humans lack basic access to primary health care due to the nature of the global economic system. It’s beyond tragedy to witness the current imposed global system launching wars to uphold “human rights” and defending “democratic values,” while denying the right to health for the majority of our fellow humans.

Several studies have revealed that crimes, wars, foreign debts, global arm trades, and economic globalization continue to directly threaten the health of poor people in the Third World (Held et. al., 1999, pp. 103-123, Mick Carpenter, 2000, pp. 336-351). Moreover, there is incontestable evidence that economic inequality and health inequity are inseparable among the rich and the poor (both between and within countries). This dynamic primarily affects children and women in the Third World. It is estimated that in 2005, “536,000 women died from complications of pregnancy and childbirth, and 400 mothers died for every 100,000 giving birth” (Maternal Mortality Ratio, MMR). The [World Health Statistic 2008](#) estimates that “the MMR was 9 in developed countries, 450 in developing countries and 900 in sub-Saharan Africa”. This means that 99% of the women who died in pregnancy and childbirth were from developing countries. In addition, the WHO estimates that 2 million children die each year from illnesses preventable by vaccines, 7.5 million die at birth because of poor health care for mothers, and 200 million are malnourished (Raleigh, 1999, Mick Carpenter, 2000).

There is a need to effectuate the normative fundamental principle of the [Universal Declaration of Human Rights](#) (UDHR) in juxtaposition with the Right to Health that has been affirmed by the United Nations. Article 25 of the UDHR accentuates the socioeconomic rights by affirming that:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

Nonetheless, the negligence of the Right to Health has annihilated the very nature of the impartial “universality” of human rights law. Today human rights have been reduced “to a set of rights that support freedoms associated with free market economics” (Tony Evan, 2000, pp. 213), and are separated from

socioeconomic rights. On the contrary, global health security requires governments and global “actors” to accept their obligations to recognize and treat the right to health as a prerequisite to the applicability of human rights laws within countries and globally. That is, in order to justify placing human rights doctrine and its legitimacy at the center of global politics.

Therefore, the logic that commodifies health care systems negates the fundamental principle of protecting and advancing the indispensable human rights’ regime that considers access to health a non-tradeable commodity. Consequently, this logic of commodification does not tend to eliminate or even reduce inequalities in health status among the poor and wealthy within nations and globally. As the DAA avowed, in order to create a sustainable process of economic and social development in the underdeveloped world, primary health care should be considered a non-negotiable right. Therefore the debate that proposes to separate the right to health from human rights law dismisses the right to health as one of a range of socioeconomic rights in which the states and governments are obligated to provide to their citizens under international laws and treaties.

The deterioration of the well-being of the peoples of the global South is triggered as a result of multifaceted policies of imposition and dependency since we know that “the health of individual is best ensured by maintaining or improving the health of the entire community” (Satcher 1995, pp.3, Farmer 2001, pp.42). The reality of poor health of the majority of the planet’s populations contradicts the minimum essential level of health policies needed to achieve a feasible “development” level, according to the necessary standard of health care as defined in international human right laws. This unpleasant reality is a reflection of the one-sided policy of commodification of all social services in the name of development and economic globalization. This reality is very prevalent in the power relations between rich and poor countries on the one hand and between poor countries and the international financial institutions on the other.

Despite medical innovations and unyielding campaigns (e.g., Millennium Development Goals) to improve health as part of the advancement of human rights worldwide, the worsening of the well-being of the global South peoples and their societies stands as a disgrace. The health challenges that face the poor include, but are not limited to: increased levels of communicable and non-communicable diseases, scarcity and patentability of medicines, environmental threats, sociobehavioral pathologies, and above all, limited access to adequate

health care facilities. These are demoralizing for the disempowered and marginalized populations.

The 'Health for All' policy is as needed and achievable today as it was thirty years ago in Alma Ata. What we lack is the political will to enforce policy of primary health care for all based on the political economy of inclusion, instead of the political economy that seeks to maximize profit and exclusion. The current economic globalization that imposed upon vulnerable populations of the global South has led to a decline in the number of social organizations that combat diseases. Economic globalization continues to disregard the socioeconomic rights of the Third World's peoples (Tony Evans 2002, pp. 197-215). The stagnation of socioeconomic rights in the global South mirrors the policies of dependency that has its roots in colonial inheritance, which has its effects on the process of economic, social, political, and human progress of the vast majority of Third World countries. Realizing that 'Health for All' is the beginning of the move to end the asymmetry of power that indeed generates inequity of health globally, shall assist in reversing the socioeconomic conditions that increasingly worsen the health status of marginalized and vulnerable populations worldwide. This dynamic of current globalization reproduces conditionality and lack of opportunity; especially for those who are far removed from controlling their destiny because their lives are determined by decisions made by others. In order for us - as a global human society - to reach humanistic solidarity, the right to health should be treated as a fundamental human rights' pillar, and not considered as a tradable commodity.

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