## Bergis Schmidt-Ehry:

## **The great denial of the right to health for all** − together let's overcome!

I'm not a scientist, I'm not a politician, I'm not a guru! I humbly pretend to be an experienced development practitioner in health. And I take the privilege of today's farewell symposium to share my thoughts with you to re- advocate for the fundamental human right to health!

When I started to work in Africa 37 years ago, modern health care was available only for a few. In the colonial time hospitals had been built to serve the colonial masters and the local elites − but the rural and the poor had not been of interest, with the exception of charity in some missionary centres.

Information from this period found overall infant mortality rate in German East Africa was 49-54 per **cent**! (Every second child died!) Still in 1945, Dr Sneath, the then Medical Director of Tanganyika, postulated that satisfactory levels of both quality and quantity of health services were impossible to achieve and concentrated the official health policy primarily on quality, **leaving** "extension until finance would be available". So the right to health remained restricted to a few!

Independence in most countries did not change much in these matters - certainly against the ambitions and good wishes of the young African leaders, which in almost all countries declared health care services for free. But again these remained available only for a few, as reachable and accessible services did merely not exist for the majority of the people. Access to health care might have been for a few per cent but certainly below 10%.

Just to take an example when in Southern Sudan in 1981 we did a medical excursion to some remote villages, people over there had not seen a health professional since the 40th - far from having any services!

So when looking on facts and figures from this time we have to recognise that the money available for health was only available for a few − and in fact produced not so bad results for those, but left the majority of people without enjoying their right to health.

Public health was confined to rules and regulations how to protect the elites. Still in 1993 in Cameroon a law was in existence − but fortunately no more applied - keeping indigenous populations out of a parameter from the residential areas of towns for reasons of hygiene and health protection. Disease control activities were designed particularly to protect the better-offs (or the valuable work force) from the risk of infection.

Fortunately starting in the seventees , health of the entire population became a concern, more comprehensive approaches became more and more fashionable. Outreach programmes tried to involve broader groups of population, and progress towards a population oriented health care system started.

Led by Dr Halfdan Mahler, one of the few visionaries of WHO, the Thirty-second World Health Assembly in 1979 launched the Global Strategy for Health for All by the Year 2000. The strategy was based on the famous Alma Ata declaration on global health policy, which became the synonym for a people-oriented and rights- based approach in health.

Let me cite the first chapter of the declaration which should be for us - stakeholders in health and development policy - as much of ethical value as the oath of Hippocrates for medical doctors:

„The Conference strongly reaffirms that health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a **fundamental human right** and that the attainment of the highest possible level of health is a most important world- wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector."

But unfortunately the implementation of a comprehensive health system seemed to be too expensive and we quickly went back to vertical and interventionist approaches in public health to control diseases − much sexier to sell and easier to show so-called "results" than building the system brick by brick, which could offer the necessary services to let people enjoy their fundamental human right on health.

When starting the ART intervention in Africa much talk was about the human rights and equity concerns. But did we really care about the human right to health and health care for everybody – or did we rather single out a target group?

German Development Policy in the Health Sector demonstrates obligation to address health as a human right. In fact we argue that there is the need to assure health as an **inclusive entitlement** that should look to the underlying determinants such as clean water, sanitation, information, education and **facilitate continuous access to health care**.

But do we really do this? When providing for the HIV Therapy did we not divert resources from other human rights based priorities? What for example is about mental health? (We think that between 1% and 4% of people in Tanzania are suffering from mental illness – with unfortunately almost no care.) What's about the many people who die in Africa by road accidents, as adequate services are not in reach? What's about hundreds of thousands who continue to suffer and die from the so-called neglected diseases like sleeping sickness, onchocerciasis and schistosomiasis?

Interestingly, in Tanzania during the time, the Care &Treatment Programme became most active and recruited lots of HIV positive people into ART treatment, the coverage on immunization (EPI) went down. It would have passed downwards the threshold if in 2009 a catch-up campaign would not have been launched. Every intervention in a complex system like the health system has effects on other parts of the system. The interventionist approach does not consider this but only looks on the narrow targets of the intervention. By this, it might become harmful for the health of non-targeted populations and by this a clear contradiction to the human rights based approach!

Today we have heard a lot of why and how we can approach the realization of this fundamental human right to health, but let me use today's privilege to have a critical look on the actual situation – and as you know me – I will not mince my words!:

**In reality we deny the human right to health to most people.**

**Let me talk about the great denial!**

*Looking on Health Funding*

We have to talk about forgotten **commitments**:

Most better-off countries have not kept their promises to increase their contribution to ODA to 0, 7 % of their gross domestic product – thus funding for health related support is denied.

African leaders committed to the Abuja target to use 15% of the overall government budget for health, we are far away - in Tanzania around 10% - thus improved health is denied.

We have to talk about **diversion of funding**:

In Tanzania we are happy that more and more ODA is captured in the national budgetary system. Well and good, but the additional funds are now constraining the budget ceilings and it seems that external funding is crowding out internal resources.

A recent study published by The Lancet found that for every dollar ODA for health government own resources have been reduced by 0,43 $ to 1,14 $. Or the other way round international Aid needs to invest 1, 75 $ to increase disbursement in health by 1 $! We even deny the funding foreseen for health!

We have to talk about **misallocation**:

Many available funds are denied for the improvement of health, as synergies are not used by vertical programmes and resources are not allocated according to the priorities – as well depicted in a recent quality audit by the Controller and Auditor General.

We have to talk about **misuse of funds**:

In many countries the health sector is within the top group of corruption. Look at the reports of auditors which reveal how much money is thus denied for people to enjoy their fundamental right to health.

But we have as well to talk about **reliability of funding**:

When in 2004 we embarked here in Tanzania on Care and Treatment − I repeatedly underlined to both donors and the Government that this move needed a long term commitment for funding for at least 20 -30 years. Today we witness that the whole AIDS programme is funded for more than 95% by external resources and the willingness of donors to allocate ODA to the control of the disease is dwindling. We have heard that in Uganda people found HIV positive are turned away as the programme cannot support the increasing cost anymore. What's about keeping our promises?

The new draft MKUKUTA foresees cluster 2, which is about social services including health, losing out tremendously. According to World Bank analysis this will result in 2.4 Trillion lower funding over the life of MKUKUTA 2.

We put growth in the focus. Growth without health? Or growth for elites again and health only for a few?

*Let's talk about human resources:*

We have to talk about **misleading policy advice**:

In the nineties, the IMF forced many African countries to reduce their expenditure on personnel. The basic idea was to hit overgrowing bureaucracies. But in reality recruitment for health and education was frozen, production of health workers reduced and human capital turned away from the health sector.

In the meantime population growth continued unchecked thus increasing the gap between need and availability. It is certainly not the only reason but an important contributing factor that in Tanzania today we witness that we have only one third of the needed human resources, of which only one third is sufficiently competent for their increasingly complex tasks and only one third of those is found where and when needed.

As health care is depending on the availability of skilled staff, this constitutes another denial of the human right to health.

We have to talk about **brain-drain**:

Production of health workers in Africa is according to McKinsey 5 times less expensive than in industrialised countries. Earnings in industrial countries however are often at least 5times higher than in countries like Tanzania. With globalization and free trade, there is no wonder that out of the insufficient production, numbers of professionals are withdrawn by the international brain- drain.

But there is brain-drain as well inside the system. As we know more and more clinicians and practitioners turn away from their curative, clinical and health promoting functions to administrative duties. More and more professionals move from service delivery to project and programme work and skilled professionals move from rural and under-served areas to towns and urban centres looking for greener grasses and better opportunities, thus deepening the one-third dilemma described above.

We to talk about **perverse incentives**: You will not be surprised that I include this point in my speech - following the ongoing discussion on allowances in Tanzania and elsewhere.

We need on-the-job training to improve competences of our workforce, we need workshops to involve stakeholders in policy and strategy development, we need meetings for harmonization and coordination. And nobody can deny paying the necessary subsistence allowances. But the emphasis must be on necessary in terms of quantity and frequency. If people attend trainings and workshops for the purpose of earning supplementary income − this might be understandable - but we better advance quickly the pay reform! We have seen people attending training workshops on the same subject three times without improvement of their skills. A nurse attending a workshop might earn as much as her monthly salary in a workshop of 5 days. People at the grass-root level call District Medical Officers (DMOs) "Daily absent medical officers". And at the same time necessary services are not available in the health facilities.

Let's be clear, all this is contributing to the denial of the fundamental human right

for health.

## Let's talk about behaviour

With students of the Muhimbili University of Health and Allied Sciences (MUHAS) we did an observational study on health ethics in 6 hospitals in the country. Within three days they registered more than 600 breaches of medical ethics according to what they had learned at the university: Ranging from under-table payments over rudeness to patients and discrimination to severe mishandling and harmful practice.

Some of the cases might have been involuntary and due to lack of competence but let's be very clear: in a more human rights competent society, most of the above mentioned cases would have called the concerned to court.

We all have heard about the child which cried for days and finally lost its arm because a tourniquet was forgotten to be released after a drip was placed. Certainly a big mistake by the nurse, but what about the supervisor, the doctor in charge, the teachers and the trainers?

Dear colleagues, the health profession is a little different from others as we are dealing with life directly and we have to reflect in all our acts the principle of "nil nocere": **do not harm**! We have to teach and apply medical ethics in a more rigorous way and we have to develop systematically more accountability to our patients and clients.

## Let's come back and talk about systems

Internationally we talk a lot about "health for all", "universal access", "universal coverage", "comprehensive services". But at the same time we tend to make our interventions "targeted", "focused"," efficient". At the same time we continue to embark on vertical interventions. At the same time we have a Global Fund on three Diseases and not a Global Fund for Health. At the same time we have an ever-growing number of global health initiatives − all well intended and we recognise that most of them have mobilised funds for the sector. But at the same time they tend to derail sufficiently planned comprehensive national strategies by pressurizing priorities not necessarily following the needs and demands of countries and people but following the international fashion and the supporters' agenda.

So what is about "demand driven", "needs oriented", "human rights based"? What's about the marginalised and vulnerable? What's about the neglected diseases? And what's about comprehensiveness?

We hear that donors, funding agencies and governments turn back to talk about systems strengthening, but the necessary re-orientation is not yet really on its way.

## Let's come back and talk about funding

Economists have for long regarded - and I believe they continue to do so − health care as a mere consumptive process and not very interesting for economics and development. We know that this is not the case! We know that without health there is no development!

But there is a more fundamental aspect: Economics give us perhaps the **means** for life and development. But health is the **precondition** for life and development.

It is unbelievable that in the global society of today we are able to quickly mobilise hundreds of billions to save banks and insurers, but that we are avaricious and over reluctant to invest in the most fundamental element of human life.

## Let me come to some conclusion and forward thinking.

We cannot continue to deny the fundamental human right to Health!

Both human rights and health are values which are not given - but we need to fight for them with continued efforts!

Despite all efforts to harmonize, support to improve health of the people remains fragmented and driven by the interest of those who provide the resources and those who influence the political agenda. We have to hold us and them accountable!

We need to ask ourselves in our daily undertakings: is what I do, is what I advise, and is what I decide supporting the fundamental human right on health − or is it contributing to the great denial?

Let me borrow from Dr Faustin Njau saying "let's walk the talk" by progressive realisation and optimal use of available resources to assure that there is:

**Availability**

of not only health facilities but of facilities that are capable of rendering goods and services,

- of skilled medical and professional personnel who receive their salaries on a competitive basis,
- of essential drugs of good quality and
- of underlying determinants of health such as clean water, acceptable

  sanitation facilities and education.

**Accessibility**

- of health services and facilities without discrimination of any kind,
- Making sure that the poor and other vulnerable groups have physical and affordable access to services in public and private health facilities on equitable basis, and that they are able to ask and receive health information without any unreasonable barriers.

**Acceptability**

of health facilities, goods and services that are gender sensitive, courteous of medical ethics and that are designed to reflect adequate measures of confidentiality and that respect the cultural values of the respective population.

**Quality**

of health facilities, goods and services that are of acceptable standard, scientifically and medically approved and are provided by skilled medical personnel.

**It is my sincere hope that today's symposium has provided a platform to deepen our thoughts on the fundamental human right to health, that we continue together to pave the stony way to achieve "Health for All – as a fundamental human right" and that we overcome the "great denial".**