

A Perspective on the History of Health and Human Rights: From the Cold War to the Gold War

DANIEL TARANTOLA ¹

¹School of Public Health and Community Medicine, Faculty of Medicine, The University of New South Wales, Sydney, NSW 2052, Australia

Correspondence: Daniel Tarantola, School of Public Health and Community Medicine, Faculty of Medicine, Samuels Building, Level 2, Room 228, The University of New South Wales, Sydney, NSW 2052, Australia. E-mail: d.tarantola@unsw.edu.au

ABSTRACT

Through the end of the Cold War, public health policies were predominantly shaped and implemented by governments and these same governments committed themselves to meet their obligations for health under international and national laws. The post-Cold War era has witnessed the entry of new actors in public health and the sharing of power and influences with non-state actors, in particular the private sector and interest groups. This article examines the emergence of human rights and the rise of health on the international development agenda as the Cold War was ending. It highlights the convergence of health and human rights in academic and public discourse since the end of the Cold War in a context of political and economic shifts linked to the ongoing economic globalization. It describes opportunities and challenges for greater synergy between health and rights and proposes a role for health practitioners.

Journal of Public Health Policy (2008) 29, 42–53.

doi:10.1057/palgrave.jphp.3200159

Keywords: human rights, cold war, right to health, health and human rights, globalization, HIV

INTRODUCTION

Human rights are the rights a person has by simply being born. They are minimum standards understood to be necessary for individuals to live in dignity. While the existence, validity, and contents of human rights continue to fuel philosophical and political debates, human rights as discussed in this article are entrenched in international treaties and declarations, as well as in national law. Drafted by the governments of the world in a 2-year period shortly after World

War II, the 1948 Universal Declaration of Human Rights (UDHR), in keeping with the optimism of the time, reflected the indivisibility and interdependence of all human rights (1). It took almost two decades to move the aspirational concepts laid out in the UDHR into legally binding obligations. By that time, in the 1960s, in the midst of the Cold War, human rights were dissected into two International Covenants: one on Civil and Political Rights (ICCPR) (2) and the other on Economic, Social, and Cultural Rights (ICESCR) (3). The “right to the highest attainable standard of health” (4) became entrenched in the ICESCR, although its realization was understood, as for all other “freedoms from fear and wants” (5), to be contingent on the fulfillment of all rights, including such rights as security or protection from torture and inhumane treatment, embodied in the ICCPR. This artificial division of rights resulted from diverging political forces both within and across nations. Many liberal economies held that, unlike civil and political rights, economic, social, and cultural rights – including the right to the highest attainable standard of health – were not enforceable or justiciable, and thus best left to individual initiatives and market forces. This historically inherited dichotomy has had long-lasting effects, primarily in the ways in which it relegated economic, social, and cultural rights to aspirational status, as compared with civil and political rights whose justiciability was more widely understood. The rationale for, and impact of the artificial division of rights remain today subjects of debate and continued controversy.

Under international human rights law, states have the obligations to respect rights (i.e. to refrain from violating rights), to protect rights (i.e. to ensure that non-state actors do not violate rights), and to fulfill rights (to ensure that there are laws, structures, mechanisms, and resources in support of human rights) (6). From a health perspective, human rights offer a set of principles particularly useful to setting state obligations in health as well as other dimensions of human development. Human rights do so by providing a framework for policy analysis and formulation, and adding – at least in theory if not in practice – a level of enforceability to the health commitments expressed by states in such fora as the World Health Assembly, in relation to what they do and do not do for their own people and the international community more broadly (7).

Born in the mid-1940s, the Cold War divided much of the world into two geopolitical blocs until the early 1990s. In the interval, it included periods of high tension – the Cuban crisis and nuclear war threats of the 1960s – interspersed with brief periods of *détente*. The ending of the Cold war began with Gorbachev’s accession to power in 1985, and concluded with the dissolution of the USSR in December 1991, less than 2 years after the fall of the Berlin Wall. This article recalls the resetting of the international health agenda in the last two decades of the Cold War and the gradual convergence of health and human rights in public health policy, suggesting that political shifts and economic globalization in the post-Cold War have fueled skepticism about the true value of rights. As political ideologies are being overshadowed by global market forces, the ending of the Cold War has given rise to the emergence of an equally brutal “Gold War,” where the human rights foundations of democracies and their relevance to health have become secondary to profit and economic growth imperatives.

RESETTING OF THE INTERNATIONAL HEALTH AGENDA

In the 1960s and 1970s, in the midst of the Cold War, international attention focused increasingly on the health challenges faced by developing countries, inappropriately answered by traditional medically focused programs and services (8). By the early 1970s, appropriate approaches to health in resource-constrained settings were discussed in a variety of circles. From this, the concept of primary health care (PHC) emerged on the international scene with the goal to reach the most underserved, vulnerable communities with a package of interventions that could be delivered with the active participation of community health workers and communities themselves (9). The 1978 Alma Ata Conference brought together state and for the first time non-state actors, not including commercial entities, to reset the international health agenda (10). The Alma Ata declaration affirmed 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 whose realization requires the action of many other social and economic sectors in addition to the health sector (11).” The ICCPR and the ICESCR had entered into force only 2 years earlier.

By the end of the Cold War, most mechanisms were therefore in place and commitments expressed to make human rights and the new international health agenda real. Mental health, reproductive health, humanitarian emergency work, and movements against torture and nuclear war are vivid examples of campaigns that built on congruence between health and human rights agendas. The geopolitical tectonic shift through which the world was about to live was to create new opportunities, but also challenges for human rights and for health.

WHAT CHANGED WITH THE END OF THE COLD WAR?

The redrawing of the geopolitical map in the 1990s did not merely impact on East–West relationships; it perversely disengaged the two blocks from their commitments to health and development in the developing world generally, with particularly negative effects for Africa where, even if for a combination of humanitarian and political motives, most foreign aid had been targeted. Aid to Africa was redirected to support Eastern European countries (12). Health indicators had deteriorated in several Eastern European countries and similar indicators in Africa were no longer improving, but leveling off or in some cases receding. For health and for global development as a whole, more needed to be done, and done differently. Attention to health as a requisite for development was re-discovered by the World Bank in its 1993 world development report, resulting in increased lending to the health sector although the bank still adhered to its structural adjustment policy (13).

Economic globalization, which arguably had started decades before the end of the Cold War with the emergence and growth of transnational corporations, was now impacting low-income countries (14,15). Following the General Trade and Tariff Agreements and a series of negotiation “rounds”, the World Trade Organization (WTO) was created in 1995 – a “rules-based” system to elaborate agreements covering goods, services, and intellectual property in the context of trade and set procedures for settling disputes (16). These agreements spelled out the principles of trade “liberalization.” They permitted exceptions, notably those that prescribe special treatment for developing countries. Those who saw themselves as the immediate victims of new trade and intellectual property

arrangements that seemingly favored capital growth over social equity and progress raised health-related claims as well as ones in the domains of the environment and agriculture (17). The Agreements on Trade Related Aspects of Intellectual Property Rights, which entered into force in 1995, have been and remain the focus of debate. Civil society, often invoking the right to life and the right to health, plays an important role (18).

Specific exceptions allowing states to take measures to protect public morals, human life or health, and public order can and did create grounds for human rights-based claims by diverse non-governmental organizations whose voices could no longer be ignored or muted (19,20). Civil Society was instrumental, and continues to play a key role in promoting economic, social, and cultural rights, in particular the right to health (21). Several other factors stimulated interest in human rights during this period, one of which was the emergence of the HIV pandemic.

HIV AND THE EMERGENCE OF THE HEALTH AND HUMAN RIGHTS MOVEMENT

The Health and Human Rights concept, principles, and practice owe much to the response to HIV. The first WHO Global Strategy on HIV/AIDS, launched in 1987, incorporated among its key strategies the protection of individuals and societies against the impacts of HIV, including discrimination against people infected or affected by the epidemic (22). The strategies were initially largely dependent on the health sector to address manifestations of HIV. In the early 1990s, as understanding of the roots of the epidemic deepened, Jonathan Mann and collaborators asserted that societal and structural factors determined or at least influenced the degree of individual risk and vulnerability to HIV. The response to HIV could no longer rely on the health sector alone: it had to encompass broad societal changes as well (23). To delineate the scope of an expanded response to HIV, human rights principles and instruments were put forward as the most practical framework of analysis and action (24,25), reminding states of obligations under international and national law. The 1996 UNAIDS Global Strategy Framework and its subsequent revisions were built around these principles and further expanded them (26).

How were health and human rights connected? By the mid-1990s, health issues including communicable and non-communicable diseases and ill health, more generally, were associated with behaviors and lifestyles as well as with occupational or environmental factors (27) based on a reciprocal relationship between the fulfillment of *all* human rights and the achievement of better health. Spearheaded by Mann, the Health and Human Rights movement – for want of a better term – was born and began to expand within the two disciplines.

THE EXPANSION OF HEALTH AND HUMAN RIGHTS

Beginning in the late 1990s, several resolutions and declarations of the UN General Assembly contained explicit references to health and human rights with regard to HIV or children (28,29). Critically, in 2000, ICESCR General Comment No. 14 on “The Right to Health” provided practical guidance on how to interpret, implement, and account for this right, drawing explicitly on the experience gained in the response to HIV (30). In that same year, the UN General Assembly adopted a declaration setting eight Millennium Development Goals (MDGs) to combat poverty by furthering development, security, and human rights (31). All MDGs are affected by or preconditions for progress in health, while the declaration, related programs of action, and monitoring mechanisms contain numerous references to human rights. International development agencies and non-governmental organizations produced policy statements on how human rights are relevant to work in health and development. Human rights treaties in this new millennium, including the Convention on Migrant Workers and their Families and the Convention on Disability opened for signature in March 2007, contain explicit references to both health and to the original indivisibility of rights concept. Health and human rights, each independently and together, seemed to have come of age in global development policies and formal commitments.

The legal use of human rights in public health has also increased. In Latin America, but also in India and South Africa, community and interest groups have used governmental obligations in relation to health under national law and/or international human rights treaties to bring court cases brought against the state (32). Their objective

was to ensure greater community access to life-saving drugs, most notably anti-retroviral drugs, to fight HIV/AIDS. The way is now open for similar cases on other health issues (33,34). Clearly, the post-Cold War era witnessed significant global progress in health and human rights were evident after the Cold War; yet, state delegations to international fora who subscribed to international commitments often went home and their country reverted to old ways of doing business. As the Universal Declaration of Human Rights approaches its 60th birthday, a negative trend with potentially damaging effects has appeared in political discourse on human rights generally, and notably on their importance to health (35). Why is this and what can be done about it?

FROM THE COLD WAR TO THE GOLD WAR?

National policies today reflect more than ever economic self-interest and respond to market forces that transcend national boundaries and decaying political ideologies. In short, the Cold War is over; a “Gold War” is raging. Expanding neo-liberalism and economic globalization press governments to create widening opportunities for private enterprise to shape and exert control over markets and influence public policy (36). Sectors that in the past fell within the realm of governmental responsibility are treated as market driven: health, heavily dependent on the managed care and the pharmaceutical and research industries; social security, increasingly in the hands of private insurance companies; education where private universities, colleges, and schools have grown while public institutions remain under-funded; and other social services that have been redesigned to minimize economic costs or generate profits rather than seek greater equality, justice, and dignity. Neo-liberal governments face dilemmas concerning their obligations under international treaties and/or national law on human rights and health: how can these obligations be met when economic investments in social and health sectors are increasingly privately owned? Can monitoring mechanisms operate effectively under widening resource gaps between weakening public services and an ever-growing private sector? What safety nets should be put in place in an economically driven society to ensure that those whose voices are not heard do not suffer from aggravated inequality and gradual exclusion from essential services?

As state obligations under national and international human rights law become subordinate to the state's wish to be a credible partner in the global market-driven economy, the notion of good governance is in peril. Further progress in health and human rights can be achieved only through research, practice and advocacy, and a stronger role for health practitioners.

GOOD GOVERNANCE AND THE ROLE FOR THE PUBLIC HEALTH COMMUNITY

Good governance means empowering people to shape their own future, with better health and better human rights. People may expect government to guarantee that human rights obligations remain central to good governance, meaning transparency, responsibility, accountability, participation, and responsiveness to the needs and aspirations of people (37). Health and human rights are universal aspirations, particularly when in jeopardy – the case for a vast and growing portion of the world's population. Considered together, health and human rights stand at the core of human development. Even the WHO Commission on the Macroeconomics of Health and the World Bank hold this view (38,39). Therefore, what should be done to combat skepticism or denial in governments and professions?

Public health practitioners can enhance research and documentation, to build evidence establishing or challenging synergy between health, human rights, and, more broadly, human development. Not a simple task. No single method is best suited to this purpose, but a combination of methods can be drawn from social, legal, policy, and health research. Extending, for example, work on social determinants of health one step further would show the failure of governments to meet national and international human rights obligations.

We might apply health and human rights principles to policies and practices (40). Human rights violations occur within health systems themselves, when they are insensitive and unresponsive to discrimination and inequality, or to the need for greater participation and accountability. These principles are fundamental to *rights-based* approaches to health (41). Public health practitioners must familiarize themselves with such approaches, apply them in their practice, strengthen them as experience is gained, and document their impacts.

Through a process of empowerment beyond the traditional charitable approaches to poverty, we can inform and educate people about their human rights to health and support their claims for better health and better human rights. Emphasis on poverty in international development is surely praiseworthy, but it may overshadow a truth that poverty is not eliminated by handing out commodities for immediate survival. Relief is a response to human distress; the fulfillment of health and human rights is a response to poverty.

ABOUT THE AUTHOR

Daniel Tarantola is a public health physician whose career has been largely devoted to international and global health under the auspices of the World Health Organization, the Harvard School of Public Health and currently the University of New South Wales where he chairs the UNSW Initiative for Health and Human Rights.

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