A case for integrating human rights in public health policy

In a global environment where human rights and well-being are coming under increasing threat, both from the spectre of terrorism and from the counter-reaction to it, and where international governance systems continue to pay lip service to poverty reduction while encouraging unbridled private accumulation of wealth resulting in huge inequalities between and within countries, the need to make human rights considerations an integral part of how public health policies are formulated cannot be overemphasised. Contestation over entitlements to socio-economic rights has troubled health care systems worldwide, from resource-poor settings in Africa, where questions have been raised as to whether human rights approaches are best suited to addressing the problem of AIDS in Africa, through to the over-consumptive USA where universal access to health care remains a policy objective doomed to unfulfilment under market-fixated economic systems.

Part of the reason why public health policies have failed to address global, regional and local disparities adequately may lie in the lack of a coherent ethical framework for public health. An alternative approach to making public policies ethical is to subject them to the scrutiny of a human rights framework, which prioritises the needs of vulnerable individuals and groups and affords protection and agency to those most directly affected by such policies, using international standards agreed in human rights law.

Although the tensions inherent in the formulation of public health policy are not unique to South Africa, South Africa’s experience with regard to national HIV policies is particularly illustrative, and has exposed deep contradictions between government’s constitutional obligations to deliver socio-economic entitlements such as access to health care, and the reluctance of policy makers to recognise access to antiretroviral treatment as a human right. The ethical contradictions facing individual health care practitioners under circumstances of Dual Loyalty have been well recognised, and addressed in a range of ethical and human rights guidelines. Yet when public health officials try to carry out their work under such circumstances, the choices facing health professionals seeking to do their best for their patients or communities are often severely limited, and represent a Dual Loyalty conflict of a particularly invidious type.

Other examples abound in our current context. For example, health workers completing disability grant applications are required to adjudicate on the fitness of their HIV-positive patients, knowing that as they recover and their CD4 count climbs over 200 cells/µl, their patients will be stripped of what is possibly their only source of income. Completion of a death certificate has presented practitioners with invidious choices about protecting confidentiality in the context of ‘discrimination beyond the grave’, while the introduction of ICD-10 coding requirements by the health insurance industry has added another challenge to confidentiality for health care providers, and to the right to privacy of medical scheme members.

Yet, in its recommendations, South Africa’s Truth and Reconciliation Commission highlighted the importance of human rights as a benchmark for the training and practice of health professionals. In this issue of the SAMJ, Mathews provides a policy critique of proposed legislation to criminalise intentional transmission of HIV, from a human rights perspective. This research arises from a module developed specifically for the Masters Programme in Public Health at the School of Public Health and Family Medicine at the University of Cape Town that has been taught over the past 3 years. The module builds on previous experience in the School’s Health
and Human Rights Programme in undergraduate teaching and train-the-trainer approaches to health and human rights teaching. A key thread of the course is to equip students with skills to critique existing policies, and/or to design new policies that better integrate human rights into public health objectives. Mathews' findings, which may appear unpopular with some, viz. that there are serious limitations to the policy of criminalisation of deliberate HIV transmission from both a public health and a human rights perspective, would not easily emerge without careful application of a rigorous critique based on the links between public health and human rights.

The challenges facing health care providers and policy makers seeking to balance social utility against individual patient welfare are not decisions to be made outside of an ethical or human rights framework. Rather, they should be justifiable in terms of high standards of respect for human dignity. There are situations where a social benefit may justifiably trump concerns for individual autonomy (for example in the use of quarantine to control serious and contagious conditions), but these exceptions have to be based on clear criteria that meet accepted standards in a transparent and defensible manner consistent with human rights. Too often, we are guided by short-term sensibilities that allow prejudice, assumptions and misinformation to define health policies. Instead, applying a human rights perspective to the development, implementation and monitoring of health policies may help to address the seeming gap between the intent of health programmes and their outcomes.

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