Essential Medicines, Equity and Human Rights: A framework for analysis & action

Informal Consultation on Access to Essential Medicines and Human Rights
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What is poverty?

Poverty is **multidimensional**:

- Low income
- Poor access to resources and skills
- Vulnerability
- Insecurity
- Voicelessness, disempowerment
- Gender
- Race
- Ethnicity
Poverty and health: the links

The vicious circle:
- Ill health leads to poverty
- Poverty leads to ill health

The virtuous circle:
- Good health is linked to higher income and welfare
- Higher income is linked to good health
The poor are at greater risk of ill-health

Prevalence of moderate underweight by average daily household, by subregion

The poor have greater health care needs

Health Status and Poverty: Viet Nam

Malnutrition
- Urban: 9.6
- Rural: 21.8
- Rural Poor: 28.4

IMR
- Urban: 10.4
- Rural: 26.7
- Rural Poor: 40

Source: ADB
The poor have greater health care needs

TB prevalence among poor and non-poor, Philippines

Source: Philippines NTP, 2000
Use of services by the poor is low

Poor-rich differences in use of basic health care
Average of 44 countries

Poorest 20%
Next Poorest 20%
Middle 20%
Next Richest 20%
Richest 20%

Inter-Quintile Ratio

- Antenatal Care (Avg: 70.8%)
- Att. Deliveries (Avg: 52.5%)
- Diarrhea - ORT Treat. (Avg: 61.1%)

Use of services by the poor is low
Gender differences in use of services:

Proportion of boys and girls (12-23 months) who have received full basic immunization coverage by income quintile, Cambodia

THE INVERSE CARE LAW

THE AVAILABILITY OF GOOD MEDICAL CARE TENDS TO VARY INVERSELY WITH THE NEED FOR IT IN THE POPULATION SERVED.

Julian Tudor Hart, The Lancet, 1971
The poor can ill afford sickness

Affordability of Health Services: Viet Nam

<table>
<thead>
<tr>
<th>Share of Persons with Health Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poorest</td>
</tr>
<tr>
<td>Second</td>
</tr>
<tr>
<td>Third</td>
</tr>
<tr>
<td>Fourth</td>
</tr>
<tr>
<td>Richest</td>
</tr>
</tbody>
</table>

Source: ADB
What barriers do the poor face?

1. Geographical access: distance, remoteness, isolation
What barriers do the poor face?

2. Economic costs:
   - Direct costs
   - Indirect costs (food, transport)
     - China: 89% of per capita income
     - Malawi: 584% of non-food monthly income (poor families) vs. 176% (non-poor families)
   - Opportunity costs: wages, time
   - Lack of safety nets
What barriers do the poor face?

3. Low knowledge and awareness, stigma, fear of social isolation

4. Lack of system responsiveness: public, private
Knowledge of HIV/AIDS Prevention (Men) -- rates among poor and rich

C: Latin America, Caribbean
E: South Asia
F: Sub-Saharan Africa
Gender differences in access to resources:

Proportion of women and men (15-49 years) who read a newspaper at least once a week, by income quintile, Philippines, 2003

Gender differences in decision-making power:

Who decides how married women spend their own income in Vietnam (percentage of women respondents)

Why address equity in health work?

**Efficiency:** Public spending in health is captured by non-poor

Benefit incidence of public spending on health

<table>
<thead>
<tr>
<th>Country</th>
<th>PHC</th>
<th>Tot</th>
</tr>
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<tbody>
<tr>
<td>C d’Ivoire</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Ghana</td>
<td>92%</td>
<td></td>
</tr>
<tr>
<td>South Africa</td>
<td>94%</td>
<td></td>
</tr>
<tr>
<td>Vietnam</td>
<td>93%</td>
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</tbody>
</table>
Who benefits from public expenditure on safe motherhood in Viet Nam?

Distribution of benefits from government expenditures on antenatal care and attended deliveries, 1996 (Millions of VND)

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Poorest 20%</th>
<th>Richest 20%</th>
<th>Poor-Rich Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Hospital</td>
<td>116</td>
<td>437</td>
<td>1 : 3.8</td>
</tr>
<tr>
<td>Provincial Hospital</td>
<td>91</td>
<td>562</td>
<td>1 : 6.2</td>
</tr>
<tr>
<td>District Hospital</td>
<td>80</td>
<td>216</td>
<td>1 : 2.7</td>
</tr>
<tr>
<td>Polyclinic</td>
<td>78</td>
<td>40</td>
<td>1.6 : 1</td>
</tr>
<tr>
<td>Commune Health Centre</td>
<td>360</td>
<td>338</td>
<td>1.1 : 1</td>
</tr>
<tr>
<td><strong>Total Benefit</strong></td>
<td><strong>726</strong></td>
<td><strong>1,593</strong></td>
<td><strong>1 : 2.2</strong></td>
</tr>
</tbody>
</table>
Why address equity…?

Health inequalities are widening

Ratio of U5MR of bottom to top quintile

- Zimbabwe
- Indonesia
- Colombia
- Philippines
- Ghana

- Late 1980s
- Mid/late 1990s

Why address equity…?
Why address equity…?

• Human rights:

“The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political beliefs, economic or social condition.”

- WHO Constitution Preamble
Right to health: Guiding principles

- Progressive realization: need for indicators, benchmarks
- Core obligations: e.g., non-discrimination
- Freedoms: e.g., consent
- Equality, vulnerability
- Participation
- Monitoring, accountability
Right to health: Guiding principles

AAAQ:
- Availability
- Accessibility
  - Non-discrimination
  - Physical accessibility
  - Economic accessibility
  - Information accessibility
- Acceptability
- Quality
States’ duties: AAAQ and medicines

- Availability:
  - Ensure adequate quantities: use TRIPS flexibilities
  - Promote R&D for diseases of the poor through incentives

- Accessibility:
  - Everywhere: rural/urban; supply system
  - Affordable: examine taxes, duties
  - Non-discrimination: sex, race, SES status, etc.
  - Reliable information

- Acceptability: cultural (e.g., rational use; traditional medicine), ethical (e.g., consent in trials)

- Quality: control counterfeit and tampering
Progressive realization and medicines

States’ duties:

• Demonstrate progress: appropriate indicators and benchmarks to

• Core obligations, with immediate effect:
  – National essential medicines list
  – Ensure availability and accessibility of essential medicines

• Progressive realization: non-essential medicines
Discrimination, equality, vulnerability

- Non-discrimination / positive discrimination
- National medicines policy: access, vulnerable groups
- National medicines supply system: targeting vulnerable groups, areas
- Address social, cultural, political barriers to access by vulnerable groups
- In M&E: collect, analyse and use data that are disaggregated by various relevant social stratifiers
Respect, protect, fulfil

• Respect: non-discrimination against excluded groups
• Protect: e.g., privatization should advance, not hinder right to health
• Fulfil: e.g., provide essential medicines to those who cannot otherwise access them
Participation

• Active and informed
• Diverse stakeholders:
  – Professional associations
  – Universities
  – Rural communities
  – NGOs
  – Patients and consumer associations
  – Representatives of disadvantaged groups
International assistance

• No pressure to accept IP standards that disregard TRIPS safeguards and flexibilities (e.g., TRIPS-plus)
• Can complement national obligations and help developing countries move towards full realization
Monitoring and accountability

- Transparent, effective
- Disaggregation, indicators, benchmarks
- National medicines policy:
  - Govt’s right to health obligations
  - Implementation plan
  - Suitable national body to assess accountability and progressive realization
Medicines: other issues

- Reliable supply system for affordable medicines: excluded communities
- Quality of medicines: regulatory capacity
- Financing: affordability, adequate public support for those who can’t pay
- Corruption: hurts the poor more; ensure transparency, accountability, information
THANK YOU