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Economic Aspects of the Right to Health in Developing Countries

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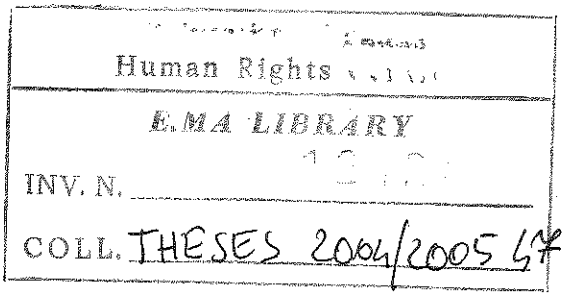

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Abstract

In the world where one-fifth of the population is living at the edge of human existence, facing starvation, malnourishment and poor health, the discussion about the right to health and its economic aspects is taking on importance. It is impossible to interpret the socio-economic rights, such as the right to health, without their placement in economic dimension. Implementation of the provisions of the International Covenant on Economic, Social, and Cultural Rights and delivery of health care is ultimately dependent on allocation of the outcome of economic activities and active participation of individuals. However, resources are limited and the economy of a state might be forced to apply some form of health care rationing.

The first part of this thesis introduces legal aspects of the right to health in the international perspective, in particular the scope of state obligations foreseen in the international human rights instruments. The further parts explore economic factors determining the realisation of the right to health and problems related to availability of resources and their allocation in health care. It addresses problems arising by application of economic concepts and methods in domain of health care, challenging the idea of free market economy in health care systems. In particular, it shows the impact of economic situation in developing countries on demand for health care and analyses several aspects of health care provision, such as resources allocation, health care financing and international assistance in health systems.

The economic constraints hindering the enjoyment of the right to health are particularly concentrated in developing countries characterized by low economic and infrastructure development, poverty, low income and its unequal redistribution, therefore a special focus has been placed on specific situation of these countries.

Introduction

Health and health care are major determinants of societal wealth and standard of life. Due to their importance for individuals as well as whole countries and international community, health and health care became fields of activity for many international agencies such as World Health Organisation, UNAIDS, the Global Fund, etc. Right to health and appropriate health care has been recognised in international treaties and other international instruments. Nevertheless, health constitutes also an economic phenomenon, which may be treated as an economic good of both productive and consumptive character. It is also and important factor defining individual and societal productivity.

Realisation of the right to health requires its placement in economic perspective and includes consideration of micro- and macroeconomic factors such as individual and national income, allocation of resources, etc. On the other hand, health and health care are products of national economy that consist of services provided to individuals. Since economies are characterised by limited resources the question of efficiency gains on particular importance.

The goal of this thesis is to explore economic aspects of the right to health that is economic factors determining its realisation and question of the state intervention in health care. Since the problem of health care is essential for developing economies where the obvious scarcity of resources is accompanied by greatest needs, this thesis focuses on specific situation of low-income economies.

This thesis has been divided into four chapters, which consist of sections referring to particular problems of health and health care. The first chapter explores legal aspects of health in the international perspective. This includes analysis of international instruments recognising the right to health in particular to United Nations Charter, Universal Declaration of Human Rights and International Covenant on Economic, Social and Cultural Rights. Its major goal is to define the scope of state obligations in the sphere of health care stemming from international law.

The second chapter presents overall economic background of health and health care. Its attempts to answer the question, why is economics relevant to the problems of health and health care. It introduces general economic concepts of scarce resources, allocative efficiency, demand, supply and market failure. A separate section is

devoted to health economics as a branch of economic science dedicated to the economic aspects of health care. An important question addresses in this part of the thesis refers to the problems arising by application of economic concepts and methods in domain of health care.

The third chapter focuses on analysis of demand for health care and its specific character. In particular, it presents the overall economic situation in developing countries and its impact on demand for medical services. On the other hand, it explores specific health problems existing in low-income economies such as communicable diseases (with special focus on HIV/AIDS) and malnutrition. It shows the correlation between health and economy both in micro- and macroeconomic scale. The last section examines applicability of economic incentives for health care recipients such as user fees in developing countries.

The last chapter includes analysis of the supply side of health care. It explores problems related to available resources and their allocation. In separate section it studies organisation of health care systems and health care financing.

This thesis combines two different methods of scientific approach: legal analysis and economic methods. A short introduction to use of economic models and problems arising from their application to social problems such as health care is included in the second chapter of this thesis.

Chapter 1 Legal and Conceptual Basis of the Right to Health in International Human Rights

Individual's health is essential for the human condition and has a direct impact on the full enjoyment of other human rights. Undermining the importance of economic and social rights, already by dividing International Bill of Rights into two separate Covenants, resulted over the years in treatment of investment in health as not valuable and necessary. Improvement of health services rarely becomes a political priority in developing countries and in terms of resource allocation is still one of the most under-funded areas of national financing.[1]

Right to health is enumerated in several major international human rights instruments. In this chapter I will concentrate mainly on those, which constitute a set of binding human rights instruments for most of the countries, regardless whether developed or developing ones. Other instruments, briefly presented only, are to serve better understanding of the notion of the right to health.

1. Right to Health in International Human Rights Law - Overview

1.1 United Nations Charter

The fundamental nature of the right to health is reflected in the specific references to it made in the Art. 55 of the United Nations Charter (UN Charter).[2] This Article obligates the UN and its member States to promote human rights and solutions to "international economic, social, health, and related problems (...)".[3] It is significant that in the same Article it is proclaimed that promotion of "conditions of economic and social progress and development"[4] are, among others, necessary for peaceful and friendly relations among nations. One could add on this occasion that these provisions are also strongly related to the realisation of the right to health. The fact that the UN Charter does not entitle individuals to claim their right to health

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[1] Sheetal B. Shah, *Illuminating the Possible in the developing World: Guaranteeing the Human Right to Health in India*, in «Vanderbilt Journal of Transnational Law», vol. 32, 1999, p. 451.
[2] United Nations Charter, signed at San Francisco, 26 Jun. 1945, entered into force on 24 Oct. 1945.
[3] UN Charter, Art. 55(b).
[4] UN Charter, Art. 55(a).

should not underestimate its general importance for the international peace and security.

1.2 Universal Declaration of Human Rights

Drafting of the Universal Declaration of Human Rights (UDHR)[5] in 1948 was one of the first meaningful projects of the UN Economic and Social Council (ECOSOC). The UDHR serves as a foundational document for the conceptualisation of human rights nowadays. In the Declaration the right to health does not appear as a separate, single right but it is integrated with the right to an adequate standard of living. Art. 25(1) UDHR specifically declares that: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of is 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 of livelihood in circumstances beyond his control". Achieving the right to an adequate standard of living is subject to simultaneous fulfilment of all its elements: food, clothing, housing, medical care, social services and social security. Though the UDHR is only a statement of policy it is remarkable that it included a provision relating to health of vulnerable groups, such as pregnant women and children, underlining their entitlement to special protection.[6]

1.3 International Covenant on Economic, Social, and Cultural Rights

The International Covenant on Civil and Political Rights (ICCPR)[7] and the International Covenant on Economic, Social, and Cultural Rights (ICESCR)[8] together with UDHR form the International Bill of Rights. Since the UDHR is a non-binding instrument, and regional conventions are limited to the certain geographical areas, the ICESCR is the only international human rights instrument that attends extensively to economic, social and cultural rights and presents norms legally binding to all States parties. The protection offered to economic and social rights under the auspices of the

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[5] Universal Declaration of Human Rights, G.A. Res. 217 A (III), UN GAOR, 3rd Sess., UN Doc.A/810, 1948.

[6] Shah, *supra* note 1, p. 453.

[7] International Covenant on Civil and Political Rights, adopted 16 Dec. 1966, entered into force 23 March 1976, G.A. Res. 2200A, 21 UN GAOR, UN Doc. A/6316.

[8] International Covenant on Economic, Social and Cultural Rights, adopted 16 Dec. 1966, entered into force 3 Jan. 1976, G.A. Res. 2200A (XXI), 21 UN GAOR, UN Doc.A/6316.

Covenant is broad, but very general.[9] Notwithstanding its contribution as a human rights guarantee worldwide, with 151 states having acceded to it, is unquestionable.[10]

The ICESCR expands and defines more explicitly the provisions related to the right to health. Art. 12(1) of the ICESCR "recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". It is clear that good health cannot be provided by a State; consequently the right to health refers rather to individual's freedoms (the right to control one's health, freedom from interference with one's health though e.g. torture, medical experiments) and entitlements (access to health care system). In terms of impact on "the highest attainable standard of health", the following factors have to be given thorough consideration: individual's biological and socio-economic preconditions and available resources in a particular State.[11] Evidently, different States have different amounts of resources available, therefore the attainable standard of health in the population varies from country to country. The right to health, as interpreted by the UN Committee on Economic, Social and Cultural Rights (hereinafter the Committee or CESCR)[12], extends to the following essential content: *timely and appropriate* ***health care***, *underlying* ***determinants of health*** and ***participation*** *of the population in health-related decision-making*.

The notion of **health care** relates to a system of health protection, which has to be established by a State in order to provide an equal opportunity for all to enjoy the highest attainable level of health.[13] Article 12(2) enumerates four general objectives, illustrating the content of the right to health, which furnish guidance in determining means to be taken by States in health care provision. States are obliged to take steps necessary for:

(a) "the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

(b) the improvement of all aspects of environmental and industrial hygiene;

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[9] Matthew C.R. Craven, *The International Covenant on Economic, Social, and Cultural Rights. A perspective on its Development*, Oxford, Clarendon Press, 1995, p. 24.
[10] Status of ratification of the International Covenant on Economic, Social and Cultural Rights, available at http://www.ohchr.org/english/countries/ratification/3.htm
[11] CESCR, General Comment No. 14, *The right to the highest attainable standard of health (article 12 of the ICESCR)*, UN Doc. E/C.12/2000/4, 2000, para. 9.
[12] The body with the primary responsibility for monitoring ICESCR, dealing also with the interpretation of the Covenant's provisions through issuing General Comments.
[13] CESCR, General Comment No. 14, para. 8.

(c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) the creation of conditions which would assure to all medical service and medical attention in the event of sickness".

In the view of the CESCR, subsections (d) and (c) of Article 12(2) indicate the right to health facilities, goods and services and require States to guarantee: access to basic preventive, curative, rehabilitative health services and health education; improvement of child and maternal care; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities; the provision of essential drugs; and appropriate mental health treatment and care.[14] The Human Rights Committee, while interpreting an inherent right to life of every human being, requires from States parties to the Covenant, to adopt necessary measures to eliminate malnutrition and epidemics, which would help in reducing infant mortality and increase life expectancy.

The second aspect of the right to health encompasses elementary *determinants of health*, such as adequate supply of safe food and nutrition, access to safe and potable water and proper sanitation, safe and healthy working conditions, and access to health related education and information, particularly on sexual and reproductive health.[15] The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health expresses an opinion that the rights to sexual and reproductive health play a key role in the struggle against intolerance, gender inequality, HIV/AIDS and poverty, therefore more attention should be paid to them.[16] Paul Hunt devoted half of his report to the issues, which are considered to be the most sensitive and controversial in international human rights law, but at the same time they are essential in combating poverty. Their importance is reflected in the eight Millennium Development Goals, out of which at least three indirectly relate to sexual and reproductive health: on maternal health, child health and HIV/AIDS. As regards other factors, no less important as the sexual and reproductive health, they are all closely related and dependant upon the realisation of other human rights, including the rights to food, housing, work, education, clean environment, non-discrimination, equality, privacy, access to information. All of these and many other freedoms form

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[14] CESCR, General Comment No. 14, para. 17.
[15] CESCR, General Comment No. 14, para. 11.
[16] Paul Hunt, UN Commission on Human Rights, *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Report of the Special Rapporteur, E/CN.4/2004/49, 2004, paras. 7-56.

an integral part of the right to health. Furthermore, States are responsible for adopting policies directed against environmental and occupational health threats, aimed at reducing and eliminating pollution of air, water and soil and informing about the impact of the use of harmful substances (cigarettes, drugs).[17]

Another important aspect of the right to health, namely an active *participation of the population in health-related decision-making*, requires from States to empower individuals to define their own health status and encourage them to preserve it. Education plays a vital role in this process. The Committee underlines the importance of individuals' participation in the organisation of the health sector, the insurance system and in political decisions with regard to health issues.

1.4 World Health Organization

In 1948 the World Health Organisation (WHO) was established as the first specialized agency of the UN. "The attainment by all peoples of the highest possible level of health"[18] became a primary objective of the Organization and "the enjoyment of the highest attainable standard of health"[19] is acknowledged as a fundamental right of every human being. Yet a definition of health, proclaimed in the preamble of the WHO Constitution, as " a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" has not escaped a well-deserved critic for being too broad and inaccurate. The substance of the term "social well-being" has never been outlined nor has it been clearly demonstrable in the performance of WHO.

Although WHO was directly involved in drafting the provisions of the right to health in the Covenant on Economic, Social and Cultural Rights, it generally has not been committed to lawmaking in the health sphere.[20] It is particularly striking, if we take into consideration the fact that WHO was established as "the directing and co-ordinating authority on international health work" with its constitutional mandate "to propose conventions (...) with respect to international health matters".[21] Instead it

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[17] CESCR, General Comment No. 14, para. 16.
[18] World Health Organization Constitution (WHO Constitution), Art.1, available at http://w3.whosea.org/aboutsearo/pdf/const.pdf
[19] WHO Constitution, Preamble.
[20] The only exception in this respect is the WHO Framework Convention on Tobacco Control, 2000.
[21] WHO Constitution, Art. 2(k).

concentrated its efforts on approaching health standards within a frame of its functional, instrumental and practical problems. Extensive research and programmes setting on the communicable diseases such as malaria and tuberculosis, environmental sanitation, nutrition and health education marked the first ten years of WHO existence.[22] WHO has always paid special attention to the health needs of women and children and only in this respect has advocated the introduction of laws providing access to free medical service for pregnant women, at delivery, and during the child's first year.[23] The Organisation was reluctant to impose on states any particular method of providing health care and maternal and child care was the only exception in its policy. [24] In the following years, WHO addressed further health domains, including occupational health, training of health professionals, medical treatment, and administrative and financial concerns for direct domestic provisions of health services. The end of colonialism released voices of developing countries calling for multilateral and bilateral assistance for basic health services and state-designed projects. It was in the same time when WHO pointed at the links between economic and social development and health.

Rights-based approach was particularly noticeable in the 1981 WHO Health for All Strategy by the year 2000, which focused on primary health care, assumed simply as the right to health. The term "health for all" was defined in the Strategy as "attainment by all peoples of the highest possible level of health" dependant on the state's available resources.[25] The policies specified in the Global Strategy included, *inter alia*: equitable allocation of health resources, both among and within states, community participation in shaping health care, coordination of health development with economic development through partnerships with other social and economic sectors devoted to development, better use of world's resources to promote health.[26] The primary health care programme did not become a binding legal rule therefore it

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[22] Steven D. Jamar, *The International Human Right to Health* , in «Southern University Law Review», vol. 22(1), 1994, p. 19.
[23] WHO Long-Term Programme for Maternal and Child Health, World Health Assembly Resolution WHA32.42 of 25 May 1979, para. 2.
[24] Katarina Tomasevski, *Health Rights*, in A. Eide, C. Krause and A. Rosas (Eds.), *Economic, Social and Cultural Rights. A Textbook*, Dordrecht/Boston/London, Martinus Nijhoff Publishers, 1995, p. 128.
[25] Jamar, *supra* note 22, p. 46.
[26] *Ibidem*, pp. 47-48.

was not readily implemented though it may serve as a guide for creation of basic content for states policies and their own definition of the right to health.

1.5 Right to Health in Other International Conventions

Under the **International Convention on the Elimination of All Forms of Racial Discrimination (CERD)**, State parties are obliged to prohibit and eliminate racial discrimination and to ensure the enjoyment of the right to public health and medical care to everyone.[27]

Similarly the **Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)**[28] deems unequal access to health care as a discrimination that must be addressed. The State parties shall take measures to eliminate discrimination against women in access to health care, including sphere of family planning. Art. 12(2) CEDAW guarantees women, on the basis of equality of men and women, appropriate services in relation to pregnancy, confinement, post-natal period and adequate nutrition during pregnancy and lactation. State parties are also obliged to grant women free services where necessary. The CEDAW stresses the importance of non-discriminatory practices in the field of health care services so that women gain equal access to them.[29]

In "The World Health Report 1998" WHO underlined the links between women's health and their status in society, stating that their health "benefits from equality, and suffers from discrimination".[30] One year later the UN Committee on the Elimination of Discrimination against Women in its General Recommendation No. 24 on *Women and Health* advised State parties to pay "special attention (...) to the health needs and rights of women belonging to vulnerable and disadvantaged groups".[31] Women belonging to disadvantaged groups are further defined as "migrant women, refugee and internally displaced women, the girl child and older women, women in

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[27] Art. 5(e)(iv), International Convention on the Elimination of All Forms of Racial Discrimination, GAOR, 2100 A(XX) of 21 Dec. 1965, entered into force 4 Jan. 1969.
[28] Convention on the Elimination of All Forms of Discrimination Against Women, entered into force 3 Sept. 1981, G.A.Res.34/180, UN GAOR, 34th Sess., UN Doc.A/34/46, 1980.
[29] Pamela Goldberg, *Women, Health and Human Rights* , in «Pace International Law Review», vol. 9, 1997, p. 274.
[30] WHO, *The World Health Report 1998* , Geneva, 1998, available at http://www.who.int/whr/1998/en/whr98_en.pdf
[31] CEDAW, General Recommendation No. 24, *Article 12: Women and Health* , CEDAW/C/1999/I/WG.II/WP2/Rev.1, 1February 1999, para. 6.

prostitution, indigenous women and women with physical or mental disabilities".[32] State parties are also called to "facilitate (...) access to productive resources especially for rural women".[33]

The **Convention on the Rights of the Child (CRD)**[34], which came into force in 1990, is a relatively new human rights instrument aiming to assure equal rights for all children. The CRD extends the right to health provisions specified in the IESCR to the child, granting it a special protection. Therefore Art. 24 of the CRD provides a relatively detailed description of the right to health. State parties are obliged to take appropriate measures to diminish infant and child mortality, ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary care, combat disease and malnutrition, provide adequate nutritious foods and clean drinking water, taking into consideration the dangers and risks of environmental pollution.

2. Human Rights Obligations under the ICESCR – Right to Health

2.1 State Obligations under Article 2 of the ICESCR

The general legal obligations of the State parties contained in the Art. 2 are of particular importance to a better understanding of the Covenant and constitute guidance for the other provisions of the Covenant. Therefore, this key Article, fundamental for the whole Covenant, will be a subject of detailed review. Article 2 of the ICESCR requires each State party to the present Covenant:

(1) "to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

(2) to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status".

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[32] *Supra* note 31.
[33] *Ibid*, para 7.
[34] Convention on the Rights of the Child, GA Res. 25(XLIV), UN GAOR, 44 th Sess., UN Doc.A/RES/44/25, 1989.

Although the realisation of the Covenant's rights is defined as progressive and might be limited by the scarcity of resources, some obligations are considered to be of immediate nature. This has been clearly expressed by the Committee in its General Comment on States parties obligations.[35]

The obligation to *"take steps... by all appropriate means, including particularly the adoption of legislative measures"* is clearly an obligation of conduct, which imposes on States parties to take immediate steps[36], that must be "deliberate, concrete and targeted"[37] towards the goal of full implementation of the rights guaranteed in the Covenant. Every State has a "margin of discretion" in choosing measures that are most suitable in its circumstances for implementing its obligations, however legislative measures are indispensable in the effective protection of the right to health and seem to be the preferred method of implementation.[38] The Committee strongly recommends the incorporation of the Covenant's provisions in domestic law, although States are not formally obliged to do so. With regard to the right to health, States are advised to establish a framework law and monitoring mechanisms for an adoption and implementation of national health strategy. Such legislation should consist of the following elements: (a) targets and the time-frame for their achievement; (b) means by which the goal could be achieved; (c) cooperation with civil society, private sector and international organisations; (d) institutional responsibility for the strategy application; (e) recourse procedures.[39] Adoption of retrogressive measures that stand against the core obligations or are inconsistent with the Covenant, repeal of legislation necessary for the continuous enjoyment of the right to health constitute violations of the Covenant's obligations.[40]

While legislative measures are required, they do not represent the only means of ensuring implementation of the rights contained in the Covenant. The Committee names also other types of means such as the development of administrative policies, public education activities, or social policies.[41] Mary Dowell-Jones extends the

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[35] CESCR, General Comment No. 3, *The nature of States parties obligations (Art. 2, para.1)* , UN Doc. E/1991/23, 1990, para. 2.
[36] General Comment No. 3 calls for action towards the full realisation of the rights "within a reasonably short time after the Covenant's entry into force".
[37] CESCR, General Comment No. 3, para. 2.
[38] *Ibidem*, para. 3; CESCR, General Comment No. 14, para. 53.
[39] CESCR, General Comment No. 14, para. 56.
[40] *Ibidem*, para. 48.
[41] CESCR, General Comment No. 3, para. 7.

appropriate means to "improved macroeconomic performance", including the reduction of foreign debt, inflation decrease and growth of export capacity, which could create a better environment for the more effective implementation of economic, social and cultural rights.[42] Due to the fact that the choice of measures is not always self-evident, the Committee requires from States to provide also in their reports "the basis on which they (means) are considered to be the most appropriate" in the given circumstances and assesses their appropriateness by itself.[43]

The *prohibition of discrimination* in relation to the right to health, which is expressed in the Art. 2(2) of the Covenant, falls also within the category of obligations of immediate nature as it is subject to neither progressive realisation nor the availability of resources. The Committee emphasises that most of the strategies intended to eliminate health-related discrimination, such as adoption or modification of appropriate legislation, have rather minimal resource implications.[44] However, inappropriate resources allocation might lead to limiting access to health-care facilities and services, particularly for those who do not have sufficient means to enjoy them.[45] States should prevent any discrimination in the provision of health care and implement a gender perspective in their policies in order to alleviate and eliminate all the barriers hindering e.g. women's access to health services.[46]

The obligation of *progressive realisation* means that a State must continue taking steps expeditiously and effectively, without any deliberate retrogressive measures, heading for achievement of full realisation of the substantive rights under the Covenant.[47] The concept of "progressive realisation" reflects the widely acknowledged constraints and difficulties for any country in ensuring full realisation of economic, social and cultural rights. Nevertheless, States are required to set up a system of clearly defined indicators and national benchmarks through which they will help monitor the process of the rights' implementation.[48] It is left upon the State to demonstrate in front of the Committee that it is making measurable progress.

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[42] Mary Dowell-Jones, *The Committee on Economic, Social and Cultural Rights: Assessing the Economic Deficit*, in «Human Rights Law Review», vol. 1, no. 1, 2001, pp. 11-31.
[43] CESCR General Comment No. 3, para. 4.
[44] CESCR General Comment No. 14, para. 18.
[45] *Ibidem.*, para. 19.
[46] *Ibidem.*, para 20 & 21.
[47] CESCR General Comment No. 3, para. 9; CESCR General Comment No. 14, paras. 31-32.
[48] CESCR General Comment No. 14, paras. 57-58.

Unfortunately, in many States parties' reports, in particular of developing countries, the absence of indicators and adequate statistical data is observed.

The origins of the right to *international assistance and cooperation* may be found in Article 1 of the UN Charter which defines one of the objectives of the UN "to achieve international cooperation in solving international problems of an economic, social, cultural or humanitarian character, and in promoting (...) respect for human rights and for fundamental freedoms". In the context of the right to health, the Committee emphasised that in situations when achievement of realisation of core obligations remains beyond State's maximum resources available for that purpose, it should seek assistance from the international community. CESCR has recommended States seek assistance for health improvement with the UN and its specialised agencies, such as ILO, FAO, WHO, UNICEF. In many developing countries international cooperation and assistance are essential for the fulfilment of their core obligations. Although there is clearly an obligation to cooperate internationally, it is not very clear whether wealthy States parties must facilitate assistance for the realisation of economic, social and cultural rights in other countries.[49] The Committee's approach suggests that developed countries as well as "others that are in position to assist" are under an obligation "to help developing countries respect (...) international minimum threshold".[50] However, it is not explained to what extent, economically developed countries have to make their resources available for those countries in need. The Committee is of the opinion that States should facilitate access to essential health services and goods in other countries, wherever possible and with regard to their available resources.[51] They should also cooperate in the provision of necessary humanitarian aid and disaster relief in times of emergency.[52] The Committee emphasises that international assistance should be sustainable and culturally appropriate and provided in a manner consistent with the Covenant and

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[49] Matthew Craven, *The International Covenant on Economic, Social and Cultural Rights* , in Raija Hanski and Markku Suksi (Eds.), *An Introduction to the International Protection of Human Rights*, Turku/Abo, Institute for Human Rights, Abo Akademi University, 2004, p. 108.

[50] CESCR, *Poverty and the International Covenant on Economic, Social and Cultural Rights* , Statement adopted by the Committee on Economic, Social and Cultural Rights on 4 May 2001, E/C.12/2001/10, 2001.

[51] General Comment No. 14, para. 39.

[52] *Ibidem*, para. 40.

other human rights standards.[53] At the international level human rights obligations are equally applied and States are legally responsible for its policies violating human rights beyond their borders as well as for policies that indirectly support human rights violations by third parties. States should respect the enjoyment of the right to health also when entering into agreements with other states and international actors. State parties which are members of such inter-governmental bodies as the International Monetary Fund (IMF), World Bank (WB) and World Trade Organization (WTO) should take into account their international human rights legal obligations and refrain from participation in decisions, that might hinder realisation of the right to health in other states.[54] It is very important that international cooperation is understood not only in terms of financial and technical aid, but also as active participation achieving equitable multilateral trading investment and financial systems conducive to the realisation of the right to health and the elimination of poverty.[55]

Utilisation of *maximum available resources* is the key problem in realising economic, social and cultural rights. Firstly, the term itself is difficult to define as both adjectives present two different dimensions, contrary to each other. As Robert Robertson rightly noted, " 'maximum' stands for idealism; 'available' stands for reality".[56] Thus, two difficulties arise in measuring progressive realisation within the context of resource availability since the Committee is not capable of determining what resources are available and whether they have been used to the maximum.[57] Availability of resources refers, according to the Limburg Principles, to those available within a State and those attainable through international cooperation and assistance. In their reports, States should demonstrate that their available resources have been accessible to all and used equitably and effectively, mindful of the health

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[53] CESCR, General Comment No. 15, *The right to water (arts. 11 and 12 of the International Covenant on Economic, Social and Cultural Rights*, UN Doc. E/C.12/2002/11, 2002, para. 23.
[54] CESCR, General Comment No. 14, para. 39.
[55] Paul Hunt, UN Commission on Human Rights, *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Report of the Special Rapporteur. Addendum. Mission to the World Trade Organization*, E/CN.4/2004.49/Add.1, 2004, para. 28.
[56] Robert E. Robertson, *Measuring State Compliance with the Obligation to Devote the "Maximum Available Resources" to Realizing Economic, Social, and Cultural Rights*, in «Human Rights Quarterly», vol. 16, 1994, p. 694.
[57] Audrey R. Chapman, Sage Russell, *Introduction*, in Audrey Chapman, Sage Russell (Eds.), *Core Obligations: Building a Framework for Economic, Social and Cultural Rights*, Antwerp, Oxford, New York, Intersentia, 2002, p. 5.

rights requirements. [58] Although States are generally free to dispose of their resources, it is unquestionable that due priority must be given to the realisation of human rights, including right to health. Thereby, appropriate choices have to be made by States in the resource allocation in order to ensure that needs of the most vulnerable sections of the population are given priority and addressed properly.

The notion of "available resources" refers directly to the economic problems such as the scarcity of resources and their appropriate allocation and therefore will be discussed in detail in further chapters of this thesis.

2.2 Elements of Human Rights Obligations in the Right to Health

Availability, accessibility, acceptability and *quality* form sets of criteria, by which the attainment of the right to health can be evaluated. In terms of previously mentioned components of the right to health, *health care* and *underlying determinants of health*, States are obliged to make them *available, accessible, acceptable* and of good *quality*.[59]

Availability is simply determined by the functioning public health infrastructure, which should provide variety of health services, possess appropriately trained medical personnel and sufficient number of health-related facilities (hospitals, clinics), acting within certain insurance system (public, private or mixed) affordable for all. Although the character of the health care system might vary from country to country, depending on e.g. State's developmental level, the State is obliged to ensure the basic goods that are crucial for sustaining life (safe and potable drinking water, sanitation facilities, essential drugs).[60]

Accessibility presents four dimensions of the concept of health care. Health facilities, goods and services have to be *information-supply-oriented* and accessible *physically, economically* and *without discrimination*. Thus, medical services and other health-related determinants must be accessible to all, especially the most vulnerable groups of the society, on a non-discriminatory basis. An adequate health care must be within safe physical reach for everyone, including persons with disabilities and

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[58] *Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights*, UN Doc. E/CN.4/1987/17, Annex, reprinted in «Human Rights Quarterly», vol. 9, 1987, paras. 25-28, p. 126.
[59] CESCR, General Comment No. 14, para. 12.
[60] *Ibidem*, para. 12(a).

country (rural) dwellers. Economic accessibility, in turn, requires that payable health-care services, whether provided through private or public entities, have to be based on the principle of equity and therefore affordable for all. Informational accessibility stands for the right to seek, receive and impart information, however with respect to the principle of personal health data confidentiality.[61]

Acceptability and *Quality* refer to health care, which has to fulfil the requirements of medical ethics, cultural scientific and medical appropriateness and good quality. In practical terms, State has to guarantee that medical personnel is appropriately educated and skilled, drugs and medical equipment are scientifically approved and unexpired and water is safe and potable.[62]

2.3 *Minimum Core Content of the Right to Health*

Minimum core content is a key concept bridging the gap between idealistic goals of the Covenant and available resources. It can be described as the essence of a single right or as a "floor" below which the State party should not fall with the fulfilment of its human rights obligations. The core content should answer the question of what a State must do first to move towards the full implementation of the Covenant rights, which constitutes a primary objective. The minimum core obligation, as formulated by the Committee in the General Comment No. 3, refers to the minimum essential levels of the recognised rights. Many scholars underscore that identifying minimum core obligations in the specific right should be the beginning of the process of realising economic, social and cultural rights and not the end.[63] The core obligations related to the right to health are addressed in depth in the General Comment No. 14 and reflect two approaches to health, medical and public health-related.[64] The medical approach defines the core obligations in terms of equitable distribution of health facilities, goods and services, non-discriminatory access to

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[61] CESCR, General Comment No. 14, para. 12(b).

[62] *Ibidem*, para. 12(c)-(d).

[63] Geraldine Van Bueren, *The Minimum Core Obligations of States under Article 10(3) of the International Covenant on Economic, Social and Cultural Rights*, Fons Coomans, *In Search of the Core Content of the Right to Education*, in Audrey Chapman, Sage Russell (Eds.), *Core Obligations: Building a Framework for Economic, Social and Cultural Rights*, Antwerp, Oxford, New York, Intersentia, 2002, pp. 147-160, pp. 217-245.

[64] Audrey R. Chapman, *Core Obligations Related to the Right to Health* , in Audrey Chapman, Sage Russell (Eds.), *Core Obligations: Building a Framework for Economic, Social and Cultural Rights*, Antwerp, Oxford, New York, Intersentia, 2002, p. 204.

health infrastructure, provision of reproductive, maternal and child health care, supply of essential medicines and appropriate training for health personnel, whereas public health perspective concentrates on the requirements to ensure access to food, basic shelter and supply of clean water, provision of immunisations and sufficient prevention, treatment and control of epidemic and endemic disease. In addition, a national public health strategy, addressing the health problems of the whole population and possessing a proper monitoring system, should be established.[65] It is very unfortunate that only few countries have introduced a comprehensive public health strategy. Lack of public health policy usually results in poor or inadequate use of resources for investments and expenditures in the health sector. The core obligations are non-derogable and a State party "cannot under any circumstances (...) justify its non-compliance" with the core content, furthermore non-discrimination and equal treatment are binding obligations even in times of severe resource limitations.[66]

2.4 The Nature of State Obligations under the ICESCR

Two methods of analysis are generally applied in the works of the Committee: one focusing on obligation of conduct and result, the other on obligations to respect, protect, and fulfil. Obligation of conduct is usually contrasted with an obligation of result but in fact both forms of obligations are similar to each other. International Law Commission defines an'obligation of conduct' as a situation where an organ of a State undertakes a specific course of action, through act or omission, which constitutes a goal in itself.[67] By contrast an 'obligation of result' requires a State to achieve a certain result through a course of conduct, the form of which is dependant on the State only.[68] Both cases include the two elements, 'conduct' and 'result', but classification of a single obligation will be dependant on stress put on either course of conduct, which often has an objective towards which it is aimed, or the outcome, which inevitably requires a certain course of action. The Committee emphasised in its General Comment on the nature of States parties obligations that Art. 2 incorporates both types of obligations, of conduct (to take steps and to guarantee non-

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[65] CESCR, General Comment No. 14, paras. 43-45.
[66] *Ibidem*, paras. 47, 18-19.
[67] Craven, *supra* note 9, p. 107.
[68] *Ibidem*.

discrimination) and of result (to achieve progressively the full realisation of the rights guaranteed under the Covenant).

Another approach towards obligations adopted by the Committee makes use of a tripartite typology of the States obligations that was developed by A. Eide.[69] This concept assumes that all human rights imply three levels of State obligations, namely the obligations to *respect*, *protect*, and *fulfil*.

The 'obligation to *respect*' requires the State, at the primary level, to refrain from interference with the freedom of the individual to take the necessary initiatives and use resources – alone or in association with others – for the fulfilment of his/her basic needs.[70] Many scholars underline that 'obligation to *respect*' applies not only to rights-holders, their freedoms and autonomy but also to resources and liberty of their actions, even in situations where States take positive action towards realisation of the rights in the Covenant.[71] States are principally called for restraint in any practice or activity, which would result in limiting equal access for all persons to preventive, curative and palliative health services. Discriminatory practices, especially related to women's health status and needs, are determined as deprivation of their rights. Adopting laws and policies that interfere with women's reproductive rights in form of restrictions on women's access to contraception and other means of maintaining sexual and reproductive health or imposing criminal penalties for having an abortion are considered to be violations of core obligations to *respect* enumerated by the Committee in the General Comment No. 14 interpreting the right to health.[72] States should also abstain from censoring, withholding or misrepresenting health-related information as well as from unlawfully polluting air, water and soil, e.g. through industrial waste from State-owned facilities.[73] Policies of non-state actors, such as NGOs, international financial institutions (IMF, World Bank, WTO) and private corporations also increasingly affect the well being of individuals and groups with

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[69] Krzysztof Drzewicki, *Internationalization of Human Rights and Their Juridization*, in Raija Hanski and Markku Suksi (Eds.), *An Introduction to the International Protection of Human Rights*, Turku/Abo, Institute for Human Rights, Abo Akademi University, 2004, p. 31.

[70] Asbjørn Eide, *Economic, Social and Cultural Rights as Human Rights*, in A. Eide, C. Krause and A. Rosas (Eds.), *Economic, Social and Cultural Rights. A Textbook*, Dordrecht/Boston/London, Martinus Nijhoff Publishers, 1995, p. 37.

[71] Craven, *supra* note 9, p. 111; Drzewicki, *supra* note 69; Eide, *ibidem*.

[72] Chapman, *supra* note 64, p. 207.

[73] CESCR, General Comment No. 14, para. 34.

tremendous human rights implications. It is suggested that such non-state actors are obliged, as a minimum, to *respect* human rights in their policies and actions.[74]

The secondary level of obligations entails on States the protection of the individual's rights from violation by third parties such as other individuals, groups, corporations and other entities as well as agents acting under their authority.[75] Asbjørn Eide notes that a State's obligation is to protect the individual's freedom of action and the use of resources against other, more assertive or aggressive subjects, powerful economic interests, such as marketing and dumping of hazardous or dangerous products, unethical behaviour in trade and contractual relations, generally against any undertakings violating human rights.[76] It is thus clear that the domain of the State responsibility goes beyond actions of itself or its agents and covers also the protection of right-holders' interests, by legislation and provision of effective remedies, against harmful interference of those third parties over whom the State has or should have control.

The obligation to *protect* includes the State's responsibility to ensure that private entities, including transnational corporations over which they exercise jurisdiction, do not deprive individuals of their economic, social and cultural rights.[77] A State has, in general, a positive duty to prevent human rights violations occurring in the territory subject to its effective control, even if such violations are carried out by third parties. In situations where the State is not in a position to safeguard the rights itself, it must regulate private interactions in an appropriate way so that individuals cannot arbitrarily deprive other individuals of the enjoyment of their rights.[78] Moreover, the State is obliged to create and implement the necessary measures structure for the effective protection of individuals' rights. These may have the character of policies, legislation, administrative regulations, judicial proceedings and remedies, inspections, and enforcement mechanisms. In the context of the right to health, obligations to *protect* include the following duties of States: ensuring equal access to health care and health-related services provided by third-parties; ensuring

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[74] Nicola Jagers, *Corporate Human Rights Obligations: in Search of Accountability* , Antwerpen, Intersentia, 2002.
[75] CESCR, General Comment No. 15, para. 23.
[76] Eide, *supra* note 70.
[77] *Maastricht Guidelines on Violations of Economic, Social and Cultural Rights* , Maastricht, January 22-26, 1997, in «Human Rights Quarterly», vol. 20, 1998, p. 691.
[78] Craven, *supra* note 9, p. 112.

that privatisation of the health sector does not harm the availability, accessibility, acceptability and quality of health facilities and services; controlling the marketing of medical equipment and medicines by third parties; ensuring appropriate standards of education and skills among medical professionals; protecting marginalized groups of society.[79] This is just an exemplification of States obligations and the list is not exhaustive. The protective function of the State is considered to be the most important aspect of State obligations with regard to economic, social and cultural rights.

At the tertiary level, the State is obliged to *assist* and to *fulfil* the rights of everyone, and in particular of those who are not able to achieve a goal of full realisation of the Covenant rights through their personal attempts. It is recommended that States parties to the Covenant give sufficient recognition to the right to health by its legislative implementation and adoption of the national health policy. According to the General Comment No. 14, the policy should guarantee, *inter alia*, provision of health care, equal access for all to nutritiously safe food and potable drinking water, basic sanitation and adequate housing and living conditions. The obligation to fulfil implies the obligations to *facilitate*, *promote* and *provide*. The obligation to *facilitate* requires States to adopt positive measures such as legislative, administrative, budgetary, judicial, promotional, including relevant national policies that enable and assist right-holders to enjoy the right to health.[80] States are obliged to take steps in order to create, maintain and restore the health of the population and in that manner to fulfil their duty to *promote* the right to health. They can achieve this goal by researching on factors favouring positive health results and providing information on them, disseminating appropriate information related to healthy lifestyle and nutrition, harmful practices and availability of resources.[81] State parties have also responsibility to *provide* the right to health when right-holders are unable, for reasons beyond their control, to realise that right by the means at their disposal.[82] The needs of certain vulnerable groups such as the poor, lower-income groups, women, children, the elderly, persons with disabilities, indigenous peoples, occupied populations, asylum seekers, refugees and internally displaced persons, minorities and the homeless shall

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[79] CESCR, General Comment No. 14, para. 35.
[80] *Ibidem*, para. 37.
[81] *Ibidem.*
[82] *Ibidem.*

be addressed as they are mostly the first victims of violations of economic and social rights[83]

[83] *Maastricht Guidelines*, *supra* note 77, para. 20.

Chapter 2 Economics of Health Care – Theoretical Background

1. Why is Economics Relevant in Health Care?

The goal of this chapter is not to explore economic theories in detail but to introduce them and analyse their applicability to the problems of health and health care. Why does economics matter when we talk about health and what problems arise while attempting to solve health care problems using economic tools are the most important questions brought up in this part of the thesis.

1.1 Economics, Scarcity and Resources

There are different ways of defining economics. One may say that economics is all around us[84] and in this statement is much of truth – economic aspects are present in everything that surrounds us. However, using our common sense we know that economics is not a physical and tangible matter but a science or bunch of theories. The easiest way of describing economics would be to say that it is what economists do or deal with. This simple and economically efficient answer leaves, however another question open, namely what economists actually do? To address this question we need to introduce the fundamental notion which underlies all economic thought – the notion of **scarcity**. According to economists, all resources available on Earth and in the Universe are finite. This scarcity of resources is confronted with unlimited character of people's needs and demands. This problem forces human beings and most probably all leaving creatures to make choices on how to use what they have to fulfil their needs and aspirations which as a matter of fact cannot be fully satisfied. Accordingly, people take decisions on what, how and for whom to produce in order to match their wants. Therefore, economics may be described as an assemblage of theories, which try to resolve the problem of allocation of scarce resources. In other words, economists study "how the society resolves the problem of scarcity".[85]

[84] D. Begg, S. Fisher, R. Dornbusch, *Economics*, Seventh edition, London, McGraw-Hill, 2003, p. 1.
[85] *Ibidem*, p. 3.

Traditional economics identifies three types of **resources**: **land**, **labour** and **capital**, modern theories added to this threesome a fourth factor – **enterprise.**[86] Land encompasses all physical resources provided by the planet Earth (e.g. natural resources, soil). In case of health care, clean water would be considered the most important natural resource. Labour means human resources which envelope not only the number of available workers but also their skills and capacities. With regard to health care people's skills and education gain on importance. To do their jobs doctors, nurses and pharmacists need to be well prepared. In some instances (like e.g. neurosurgery) they obtain necessary competence after years of experience. Capital denotes all product of human activity such as financial means but also buildings (hospitals, laboratories, pharmacies) and machinery (ambulances, x-rays). Enterprise connotes knowledge of how to organize things in an efficient way, in other words how to combine all other types of resources to achieve the best level of satisfaction. Enterprise is to some extent product of economics.

1.2 Efficiency

Economists often use the term 'efficient'. So do other people by saying that one thing is more efficient than the other or that one solution is more efficient than the other. In economics the notion of efficiency is closely associated with allocation of resources. The most common economic theory referring to efficiency is a theory named after an Italian economist Vilfredo Pareto. According to his idea, allocation of resources is efficient (or Pareto-efficient), if a change to it cannot make one person better off without making another worse off.[87] In Pareto-efficient state all available resources are used to their maximum.

In cases, where for some reasons it is necessary to sacrifice one person's wealth for another, this traditional approach to allocative efficiency is replaced by a theory of 'Kaldor-Hicks efficiency'. According to it, the criterion of efficiency is met, when the total social benefits yield by a change to an allocation of resources

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[86] M. Green, *The Economics of Health Care*, Office of Health Economics, London, e-source available at: www.oheschools.org, p. 6.

[87] D. Begg, S. Fisher, R. Dornbusch, *supra* note, pp. 214 – 215; J. Appleby, *Economic perspectives on markets and health care*, in W. Ranade (Ed.), *Markets and health care: a comparative analysis*, Essex, Addison Wesley Longman, 1998, p. 36.

compensate or exceed total costs. This thought is often used in economic analysis of state intervention into free market.[88]

Apart from allocative efficiency, economists and entrepreneurs often use a category of productive efficiency which is associated with a rule governing most private undertakings: to achieve the best outcome at the lowest possible cost.

It seems obvious that both productive and allocative efficiency might serve as a criterion to judge use of resources in order to accomplish state obligations arising out of the right to health. Therefore, economic analysis is an important and useful tool in addressing the problems related to implementation of this human right.

1.3 Health Economics

As we can see from aforementioned statements, economics can provide us with methods that might be very useful in deciding on allocation of resources. For that reason, a whole branch of economics, which deals with health issues and which attempts to apply economic theories to the problems of health has been developed. Four most important questions, that health economics addresses are:

1. What should be the society's decision on distribution of resources between medical and non-medical goods and services? How to "allocate resources between competing demands?"[89] This question concerns problems of macroeconomic choices the society has to make.
2. What kind of medical goods should be produced in particular by national economy? After the society decides what share of national income has to be assigned to production of medical goods and services, it has to determine what kind of goods and services and in what proportions suit its needs best.
3. What specific resources should be used to provide the health products that the society decided to produce?
4. Who should be the recipient of health products and how (according to what principles) they should be distributed among the members of the society?[90]

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[88] B.R. Cheffins, *Company law: theory, structure and operation,* Oxford University Press, 1997, p. 15; This criterion corresponds with the net benefit calculus. See: R.E. Santerre, S.P. Neun, *Health economics: theories, insights and industry studies,* Chicago, Irwin, 1996, pp. 14 – 15;

[89] B. McPake, L. Kumaranayake, C. Normand, *Health economics: an international perspective,* London, New York, Routledge, 2002, p. 3.

[90] R.E. Santerre, S.P. Neun, *supra* note, p. 4.

To answer these and other questions health economics refers to systems of distribution known to men. One of them is free market, where the decisions on distribution of goods are made by the 'invisible hand' or in other words by self-propelling mechanisms of market, the other – distribution commended by the state. Both systems will be subject to deeper analysis in the further part of this chapter.

1.4 Problems in Applying Economic Approach to Health

In applying economic approach to spheres of life other than business we encounter numerous problems that stem partially from common mistakes and partially from the nature of matter, which is to be treated, using economic tools. One of the commonly made mistakes in judging the economic approach to health and other areas of social life is to associate economics with free market approach. Free market is one of the systems that economists deem appropriate to regulate distribution of goods. In some instances, however free market does not seem to be the best way of managing matters. People consider free market as impossible or undesirable to apply in many domains of public life for various reasons, among which are so called market failures. Sometimes this leads to a conclusion that economic methods should not be applied in certain spheres of life. This assumption is clearly wrong. As a matter of fact, economics has to be seen as a social science, which studies people's behaviour. Therefore, even in domains where free market fails to be an efficient and desirable mechanism of distribution, it is still possible to apply economic tools to explore people's behaviour and incentives that make them take certain decisions in order to improve allocation of goods.

Another common mistake is related to the methods that economics as a science use. Economic analysis has been accused of one-sidedness in scientific approach. This is due to the fact that most of the economic studies involve only two or maximum several factors and correlation between them. This is however, part of the very nature of economic method. When we look into the textbooks in economics, we immediately notice that they are full of diagrams containing curves illustrating some economic theories. All of them have in common one feature – they are two-dimensional, hence they easily fit on two-dimensional piece of paper. They usually demonstrate certain relationships between chosen pairs of factors such as price and demand, price and supply, level of taxes and state income, etc. All of them are drawn with one common presumption that other factors that are not reflected in a diagram

remain the same. This fundamental principle of economic methods known to economists as ceteris paribus has to be born in mind by all persons to whom economic studies are addressed. Relationships illustrated by diagrams are true but only if we presume that other factors do not change[91].

While applying economic approach to some spheres of social life we need to bear in mind that economic or pecuniary factors are not the only incentives that society takes into consideration in deciding on allocation of goods and resources. This might be due to the fact that the society values some things higher than money and that the society may have other than purely economic goals. A very clear example of such situation may be found in health care. People usually value health and life higher than money. Therefore, they may decide to follow a very expensive treatment even if its chances of success are minimal.[92]

2. Health as a Commodity

2.1 Economic Definition of Health and Health Care

Health is a phenomenon that evades a classical definition or measurement. Generally, we seem to know what means to be healthy and we tend to define health in a negative way as a contradiction of state of being ill. Oxford dictionary defines health as a "state of being well and free from illness in body and mind".[93] As mentioned in chapter 1, WHO goes beyond this rather negative definition and defines health as "a state of complete physical, mental and social well-being, and does not consist only of the absence of disease or infirmity".[94]

Economists see health slightly differently. For them health may be treated as an economic phenomenon. Health, as a commodity, is highly desirable and can be used both in consumption (it defines individual's quality of life) and production (a healthy person can allocate his/her time and vitality to work)[95]. Generally, every human being is born with a certain potential of health and consumes it during his/her life. By making different choices we can dispose over our health potential or make

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[91] More on methods of economics see: D. Begg, S. Fisher, R. Dornbusch, *supra* note, pp. 14 – 25.
[92] See the „ Child B case" in M. Green, *supra* note, pp. 12 – 13.
[93] *Oxford Advanced Learner's Dictionary*, Oxford University Press, 1995, p. 551.
[94] See chapter 1 point 1.4.
[95] R.E. Santerre, S.P. Neun, *supra* note, p. 22.

investments in health (e.g. by eating low caloric and low cholesterol food, visiting fitness clubs, etc.). By spending our resources on improvement of our health we invest in future events and expect to receive utility from undertaken investments in the future.

Health cannot be measured in money. However, as many other economic categories, it is a subject to the **law of diminishing marginal utility**, which says that with each additional unit of a certain good we obtain lesser marginal satisfaction. In other words, consumption of each extra unit of a certain commodity generates smaller and smaller enjoyment.[96] Consequently, we put smaller and smaller values on each additional unit we receive. With regard to health this can be illustrated by the following example. A person who is ill and therefore, needs to stay in bed will pay much to become healthy and get back to work. He/she will be able to sacrifice money and time to visit a doctor, buy medicines and undergo appropriate treatment. However, if the same person feels better and its state allows him/her to work, his/her motivation to continue treatment declines. In other words, we appreciate health much more when we are sick than when we are healthy.

One of the most important factors that determine people's health is **health care** as an assemblage of goods and services aiming to improve, maintain or restore physical, mental and social well-being.[97] Health care consists in larger part of services than tangible goods. Both, its quality and quantity, are therefore not easy to measure or analyse due to the nature of health care, which includes apart from its **intangibility**, such features as: **inseparability** (i.e. the fact that production and consumption of health care happens at the same time), **impossibility to accumulate** (we cannot undergo medical treatments in advance or store them for future sicknesses), **inconsistency** (no two medical treatments are exactly the same, since human-beings are not the same)[98], **differences in quality measured ex post and ex ante** (effects of treatment are hard to forecast)[99].

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[96] D. Begg, S. Fisher, R. Dornbusch, *supra* note, p. 70 – 71; R.E. Santerre, S.P. Neun, *supra* note, p. 22 – 23.

[97] It is worth mentioning that health care is only one of many factors determining health. The other are for instance: clean environment, access to clean water, education, income, etc. Health care is, however, the factor that is mostly discussed by the economists of health.

[98] „Health care is an extremely customized product" See J. Appleby, *supra* note, p. 38.

[99] R.E. Santerre, S.P. Neun, *supra* note, p. 25.

2.2 *Health (Care) - Private or Public Good?*

Macroeconomics uses the term '**public goods**' to describe all commodities and services that may be characterised by two following features: (1) it is possible for one person to consume a public good without reducing its amount available for others, (2) costs of exclusion of some people from using public goods are very high and make such an exclusion not feasible[100]. A public good can be utilised by many persons simultaneously and in unlimited amounts (theoretically). By contrast, private goods may only be consumed by one person who by doing so preserves others from consumption. A private good is entirely used up in a process of consumption. Public goods are provided by nature or by governments, which are usually obliged to guarantee them to everybody. The most eminent examples of public goods are clean air and national defence[101].

Another phenomenon, closely connected with public goods, is a problem of "**free riders**" – persons who take advantage of public goods without paying for them. Free riders get exactly the same amount of national defence than any other citizen whether they pay for it by paying taxes or not. Existence of free riders is a direct consequence of impossibility to exclude non-paying beneficiaries of public goods from their consumption.

Some people tend to treat health and health care as public goods. This view is neither entirely right nor hundred percent wrong. In fact, many factors that determine individual's health are indeed public goods[102]. One of them is above-mentioned clean air, clean environment and public health education[103]. In an obvious manner environmental factors influence level of individual and societal well-being.
On the other hand, services in health care are typical examples of private goods[104]. As mentioned above, health care as a commodity is inseparable i.e. it is produced and consumed simultaneously. Therefore, it cannot be consumed by several persons at the same time (excluding example of group therapies) and if consumed by one person it cannot be consumed by another. Nevertheless, health care has some features of a

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[100] D. Begg, S. Fisher, R. Dornbusch, *supra* note, p. 232.
[101] *Ibidem*, R.E. Santerre, S.P. Neun, *supra* note, p. 243.
[102] Some authors apply to health care different degrees of public good characteristics from pure public to pure private goods: B. McPake, L. Kumaranayake, C. Normand, *supra* note, p. 58.
[103] *Ibidem.*
[104] R.E. Santerre, S.P. Neun, *supra* note, p. 242.

public good. In health care systems in which the state guarantees access to medical care for everyone regardless of his/her contribution, existence of free riders is unavoidable. This kind of state guarantee was included in the Polish Constitution of 1956 and implemented by the communist state. It is worth mentioning that the system of state guaranteed health care never worked properly due to several reasons. One of them was scarcity of resources combined with lack of any economic incentives to act efficiently. Medical care, although promised to be accessible for everyone, was provided in a very inefficient way. Publicly employed doctors had no motivation to avoid waste of resources the state could provide. Consequently, both quality and accessibility of medical services were generally questionable. This situation led to development of black market for medical care. State-employed doctors were 'informally paid' to render some more sophisticated services in publicly held hospitals. Accordingly, medical services were available only to the wealthy. Unfortunately, despite many efforts to reform health care system in Poland, black market mechanisms did not cease to function[105]. This is partially caused by the fact that Polish government is still obliged by the Constitution of 1997 to provide health services[106]. This example shows that fully commanded system of health care distribution in which the state ensures full access to medical services and where no economic incentives exist, has little chances to succeed.

3. Market for Health (Care)

3.1 Demand

Demand for Health Care

Economists describe demand as amount of goods that consumers want and are able to buy at conceivable price.[107] Most people perceive demand for medical services as something that has no or only limited relationship to price. This assumption is certainly true in case of some life-threatening diseases. If facing heart attack, we do not think of costs while calling the emergency ambulance. Most important is to

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[105] In Polish newspapers there are many articles describing cases of doctors accused of demanding 'informal payments' in exchange for some sophisticated medical services.
[106] Article 68 sec. 1 of the Constitution of the Polish Republic of 2 April 1997. English version available at: http://www.sejm.gov.pl/english/konstytucja/kon1.htm.
[107] D. Begg, S. Fisher, R. Dornbusch, *supra* note, p. 26.

receive medical help as quickly as possible no matter at what costs. However, most medical services are not of life-saving nature and therefore may be analysed in relationship to their costs.[108] Since medical care as a commodity is a subject to the law of diminishing marginal utility relationship between demand for medical services and their prices is inversely proportional – the higher the price of certain health care service, the smaller is demand for it. Generally, law of demand in health care seems to be the same as elsewhere, this is, however, only partially true. In fact, describing people's demand for health care by means of the same economic categories as e.g. demand for bananas, is a little problematic.

Problems with Demand for Health Care

Demand is created by buyers – people who want and are able to pay certain price for certain amount of a certain good. In case of health care everybody is a potential buyer, since everybody sooner or later will get ill. The problem is that nobody can really predict when will he/she get ill and what kind of treatment will he/she need. This makes decisions regarding health care quite complex. Response to this kind of problem is health insurance, which guarantees us to pay for our medical expenses when we will need it. Insurance, however, spoils the market by making people over-consume health care. People holding insurance demand services they would not need, if they had to pay for them directly[109].

The fact that everybody may become a buyer on the market of health care has another negative consequence that an average patient has only a very vague idea of the kind of services he/she really needs. The complicity of contemporary medicine causes that costs of getting sufficient information to make reasonable decisions on the market of health care exceed benefits. Since nobody would bother to study medicine before visiting a physician, doctors became patient's major source of information about available and suitable treatments. They act as agents mediating between patients and suppliers of medical services and goods. To some extent however, they are suppliers as well. Patients trust their doctors and agree for whatever treatment they prescribe, therefore patients' freedom to make reasonable decisions remains limited.

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[108] R.E. Santerre, S.P. Neun, *supra* note, p. 44.
[109] M. Green, *supra* note, p. 40, R.E. Santerre, S.P. Neun, *supra* note, pp. 58, 73 – 75.

Price Elasticity

Economists use the category of 'elasticity' to describe how demand reacts to changes in price. The more demand changes in response for a price change the more elastic it is.[110] Demand for some medical services and goods is inelastic. Life-saving treatments or drugs are considered necessities and demand for them seem to be independent of their price. Nevertheless, necessities in health care constitute only a small percentage of all medical services. For some types of medical care demand may be more elastic (e.g. cosmetic surgery).[111]

Is Demand for Health Care Infinite?

It is alleged that demand for health care is unlimited and constantly growing. Growth of demand for medical services is usually considered to be the main factor entailing crisis of health care systems in industrialised countries. This phenomenon is deemed to be caused by three basic reasons: (1) changes in age structure of a society, (2) emergence of new technologies, (3) growing public expectations caused by increasing income.[112] This assumption is, however, partially based on erroneous reasoning. Increasing number of older people and aging society give rise to upsetting the balance between those who effectively work and those who have to be supported by the society. Nevertheless, it does not influence the demand for medical services to the assumed extent. In fact, rise in costs of health care is related to the process of dying rather than age.[113] Statistically, people spend most on heath care in the last years of their lives regardless of age. On the other hand, innovations lead rather to decrease in costs of health care. Costs of new technologies and drugs, which are usually expensive during first years after their introduction, diminish. Price reduction of such goods extends range of available treatments and curable diseases. However, as it will be shown in the next point of this chapter, people's demand is based rather on their needs than wishes. The predictions based on assumption of constantly growing demand are too pessimistic. As a matter of fact, the population is finite and in case of

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[110] Price elasticity of demand equals the percentage change in the quantity demanded divided by percentage change in its price. Demand is elastic if elasticity is less than –1; it is inelastic if elasticity lies between –1 and 0. D. Begg, S. Fisher, R. Dornbusch, *supra* note, pp. 41 – 43.
[111] R.E. Santerre, S.P. Neun, *supra* note, p. 67.
[112] M. Green, *supra* note, p. 5.
[113] S. Frankel, S. Ebrahim, G.D. Smith, *Limits to demand for health care,* in «British Medical Journal», vol. 321, 2000, p. 43.

industrialised countries is growing slowly. On the other hand, only a certain percentage of the population will need and want to be medically treated.[114]

Need or Demand?

One of the main reasons why demand for health care cannot be analysed by means of the same instruments, as e.g. demand for bananas, is that demand for health care reflects people's needs rather than wants. Medical services cannot be traded like other consumption goods. Visiting doctors or undergoing surgeries are not the most effective and pleasant ways of spending time and money. Most medical services are related to some kind of suffering, risks (in case of surgeries) and side effects (in case of drugs). But even the simplest visit to a general physician is time-consuming and not necessarily pleasant. It is obvious that people who do not need to take antibiotics will not decide to buy them if the price for antibiotics decreases by 50%. Accordingly, nobody would take two pills of a drug instead of one only because its price was reduced. Taking drugs is neither pleasant nor hundred percent safe for health. A doctor would not send a patient for bypass surgery only because bypass became cheaper or fashionable. We take only a certain amount of aspirin to heal a flu and thus if we exceed specific portion of medicine we can ultimately die of overdose. Two visits to a doctor will not make our flu passing faster or in a more pleasant way. These examples show that in cases of most typical medical services demand does not reflect people's wants but their justified needs. Therefore, curve of demand for most medical commodities will be finite both on its bottom and top, because demand for medical care is determined by need and necessity.

3.2 Supply

Supply of Health Care

In general economics supply is defined as quantity of certain good that producers are able to deliver at any given price.[115] Since producers tend to maximise profits, they want to produce more and for higher prices. Only most efficient producers can provide goods at low prices. The higher the price, the more producers are attracted to manufacture specific commodity. Apart from the price, technology,

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[114] *Ibidem*, p. 45.
[115] D. Begg, S. Fisher, R. Dornbusch, *supra* note, p. 27;

amount of available resources and their costs influence supply. In case of supply of health care, resources consist of qualified personnel (physicians, dentists, nurses, chemists), capital, buildings, ambulances, medical machinery, etc.

Price Elasticity

Similar to demand, supply may be characterised by means of elasticity, which tell us how much supply changes in reaction for the change of price. Contrary to demand, elasticity of supply has always a positive value i.e. supply increase in response for the rise of price. Supply of health care has however, a specific character, since its growth is generally limited by necessity. Even by the highest prices, hospitals may perform only limited amount of surgeries. This limitation stems from the fact that they may operate only when it is necessary i.e. when there are patients who need to undergo a certain treatment. Furthermore, rendering health services requires high level of experience and professional knowledge as well as complicated technologies. Therefore, response of the supply side for changing price does not come immediately. In terms of the health services, it might require e.g. time and financial means to educate new physicians.

Economy of Scale

Economists claim that costs of manufacturing of a certain commodity shall decline when a production is performed in larger amounts, due to the fact that some costs related to business remain constant regardless of volume of produced goods. In health care this phenomenon exists in limited scope. Hospitals are considered to be large in terms of number of specialisations covered than services rendered.[116] Hospitals and medical practices have limited possibilities of expansion because their customers usually stem from local communities. On the other hand, it is feasible to combine some specialisations, so that they can use certain common equipment in order to reduce costs (economics of scope).

3.3 Market Failure

When the price for which producers want to manufacture certain amount of a specific good equals price that consumers want to pay, market reaches its equilibrium.

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[116] B. McPake, L. Kumaranayake, C. Normand, *supra* note, p. 36 – 37.

For classical economists free market is the best and the most efficient system of distribution. In this system price decides what, how and for whom a certain good is produced. Free market however, functions exclusively, if a number of prerequisites (such as freedom of entry to the market, perfect competition, perfect information, large number of market actors) are fulfilled. These ideal conditions are rarely met, thereby market does not work perfectly. Term 'market failure' encompasses all situations in which market equilibrium does not satisfy criterion of efficiency.[117]

Market for health care is characterised by more market failures than any other domain.[118] The reasons for this situation have been already pointed out above however, a complete summary of the market failure roots in the sphere of health care is provided hereafter.

Efficiency vs. Equity

John Appleby underlines that health care is neither suitable nor desired to be governed by mechanism of a free competition.[119] This thought refers to the question of social preferences and values. Efficiency might be seen as a value, which can be easily achieved by applying free market mechanisms. Market's 'invisible hand' helps to deliver best possible services for the lowest possible price. It seems however, that society has other concerns than profit and costs while approaching health care. In profit driven health care systems medical services are available only to those who can afford them. Example of heath insurance system in the USA shows how unequal and socially harmful might be results of applying free market principles to health care.[120] People value higher equity and justice than efficiency.. This feeling of social justice is reflected in the texts of international instruments. The goal is to make health care equally accessible for everybody, whereas maximisation of resources remains a mean to achieve it.

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[117] D. Begg, S. Fisher, R. Dornbusch, *supra* note, p. 218.
[118] Xingzhu Liu, *Policy Tools for Allocative Efficiency of Health Services* , Geneva, WHO, 2003, p. vii.
[119] J. Appleby, *supra* note, p. 38.
[120] More than 45 millions Americans lack health insurance. See J. Hopkins Tanne, *Figures show more Americans do not have insurance*, in «British Medical Journal», vol. 329, 2004, p. 530.

Asymmetry of Information

Information is crucial prerequisite to make reasonable choices. In the market economy price is the most important carrier of information. Since doctors possess necessary knowledge about available and suitable treatments and drugs, they have advantage over their patients. In many cases they act as agents and producers causing 'supplier induced demand', when they impose on patients the necessary treatments.

Monopolies

Another reason why market for health care diverges from the model of perfect competition is the existence of monopolies. Local hospitals and doctors are monopolies in their neighbourhoods because patients usually tend to choose places of treatment close to their homes. Phenomenon of monopolies is closely related to the high costs of entry into the health care market. It is extremely expensive for a modern hospital to buy equipment, but even in case of general physicians entry has to be paid in the form of years of education and practice.

3.4 Conclusions

The 'invisible hand' of market forces does not provide us with satisfactory methods of distributing goods and services in health care. An alternative system of command economy is not free from disadvantages. Directed economies do not use the concept pf prices and even if they do so, prices do not carry any information about products, their quality and costs. In the economy, where the market is regulated by the state, producers lack incentives to act efficiently, thereby wasting precious resources. In the sphere of health care, commanded economy deprives patients of their decision-making powers. Patient's choices are limited to one alternative whether he/she wants to be treated or not, leaving other decisions in hands of doctors or public authorities. As shown in the example of communist Poland, commended economy leads to the emergence of black markets, where certain goods are accessible only to the wealthy.

The choice the society has to make on how to distribute health care does not consist in dichotomy of planed economy and free market. In fact, health care in most countries is governed by mixed systems in which free market elements are combined with the state intervention. Health care economics explores questions of where the state intervention is necessary, what economic incentives might be used and what is

the impact of micro- and microeconomic factors on distribution and production of health care.

Chapter 3 Demand for Health Care in Developing Countries

This chapter is devoted to the analysis of demand side of health care in developing countries. Its principal goals are: to display the difference in understanding of demand for medical services in developing countries; to indicate specific circumstances and needs existing in the poorest countries of the world; and finally, to explore interdependence between development and health.

1. Inelasticity of Demand

As demonstrated in the foregoing chapter, demand for health care is determined by individuals' needs rather than wants or wishes. In developing countries people's needs play even a greater role in defining demand for health care i.e. amount and kind of medical goods and services they purchase. This fact may be explained by several factors among, which the most obvious are: more essential character of health needs and specific health problems occurring in developing countries.

In industrialised countries demand for health care is more and more related to people's wants and preferences, which play an important role in such branches of health care as cosmetic surgery, osteopathy, paramedical treatments or food supplements. These academic examples for free market economy in health care[121] represent commodities, for which demand is dependant on typical economic factors such as price, consumers' income and preferences. They are characterised by high price and income elasticity of demand.

In developing countries, demand for health care consists mostly of life-saving treatments and drugs, vaccinations, treatments of lethal diseases (e.g. HIV/AIDS). It is followed by demand for necessities such as clean water, sanitation and housing. In microeconomic scale, which refers to a single household, resources are allocated in order to cover these most vital needs. When existence of the whole family or life of its members is at stake, people to use all available resources to fulfil these needs by surrendering other expenditures, selling out or pledging family assets (including productive assets such as land).

Microeconomic relationship between income and expenses on necessities is well established in economy: the poorer the household the higher is the percentage of

[121] M. Green, *supra* note, pp. 17 – 18.

income spent on necessities.[122] Low income combined with high level of expenses on most indispensable goods prevent people in developing countries from purchasing 'more luxurious' health care (such as food supplements in form of vitamins), which are characterised by higher price elasticity.

For the aforementioned reasons, demand for health care in least developed countries is inelastic; thereby people are able to pay high costs to obtain necessary medical care. On the other hand, poor are less likely to seek medical help, because of lacking resources for out-of-pocket payments and weak infrastructure and large distances from nearest medical points.

Even in those countries, where basic medical services are provided by the state or international agencies at no charge, the costs of medical treatment may be paid in form of time spent on healing or costs of transportation to the nearest hospital. When the main breadwinner of the family is excluded from work due to his/her illness, the burden to maintain the household shifts to other members of the family. To take over this duty, children have to work instead of learning. Economists say that 'there is no such thing as a free lunch'. Even, if heath care is gratuitous, the family incurs costs of lost opportunities.[123]

When the family resources are shifted from other purposes to healthcare, the overall productivity of a household and its perspectives for future earnings diminish. Children, who were not sent to school, because they had to work en lieu of their parents or other adult members of the family have limited chances for better living than their parents. Sickness and poor health condemn whole families in least developed countries for life in penury, therefore it is essential for the states and international community to provide these people with basic medical care for no or very little charge.

2. Specific Problems Related to Health Care

2.1 Economic Situation

The term 'developing countries' is not easy to define and as such has many definitions in the international expert literature, which refer to different factors and thresholds of economic development. For the World Bank, this term encompasses

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[122] D. Begg, S. Fisher, R. Dornbusch, *supra* note, pp. 48 – 49.
[123] D. Begg, S. Fisher, R. Dornbusch, *supra* note, pp. 7, 463.

low- and middle-income countries, in which GNI per capita does not exceed $9,386.[124] Low-income countries are characterised by GNI per capita of $765 or less. Middle-income economies are those with a GNI per capita of more than $765 but less than $9,386.[125] In this thesis term 'developing countries' refers to the lowest-income economies or least developed countries, thus to the threshold of $2 per day per person.[126]

Regardless of definition, developing countries represent economies in which the standard of living and the overall economic situation is the worst. According to the World Bank *World Development Indicators 2005,* more than 20% of developing countries population lives on less than $1 a day.[127] Despite the progress made in the recent quarter of century, when the number of poorest people decreased by a quarter, still 1.1 billion people live in extreme poverty.[128] Sub-Saharan Africa is considered to be the poorest part of the world, where the number of people living on the $1 per day basis is actually growing and it has almost doubled within the last 25 years.[129] Sub-Saharan Africa belongs to these regions of our planet, in which health problems occur in magnification.

As a result of poverty, people living in Southern Africa have the shortest life expectancy at birth (LEB), which in average amounts to 49 years.[130] In some countries of the region statistics look even grimmer: in Sierra Leone LED amounts to 34 years only, whereas in Angola, Swaziland, Zambia and Zimbabwe it does not exceed 40 years.[131]

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[124] World Bank, *World Development Report. A Better Investment Climate for Everyone,* World Bank, Oxford University Press, 2004, p. xvi; D. Ray, *Development Economics,* Princeton University Press, p. 3.

[125] Word Bank, *World Development Indicators 2005,* available online at: http://www.worldbank.org/data/wdi2005/wditext/Cover.htm.

[126] H. Kloos, *The poorer Third World. Health and health care in areas that have yet to experience substantial development,* in D.R. Phillips, Y. Verhasselt (Eds), *Health and Development,* London – New York, Routledge 1994, p. 199.

[127] *World Development Indicators 2005, supra* note.

[128] *Ibidem.*

[129] *Ibidem.*

[130] *Macroeconomics and health: Investing in health for economic development,* Report of the Commission on Macroeconomics and Health, J.D. Sachs (Chairman), World Health Organization, Geneva, 2001, p. 24.

[131] World Health Organization, *The World Health Report 2004: Changing history,* World Health Organization, Geneva, 2001, pp. 112 – 119.

2.2 *Communicable Diseases*

Communicable diseases (such as HIV/AIDS, malaria, tuberculosis) constitute the major cause of deaths in Sub-Saharan countries.[132] Paradoxically, they seem quite easy to prevent and counteract even with limited financial means. On the other hand people, living south from Sahara are more susceptible to this kind of diseases, due to: lack of sanitation, lack of potable water, climatic and environmental factors, lack of safe housing, education and medical information. Cultural and religious factors are also worth mentioning in reference to prohibition of condom use or unequal status of women.

Preventing communicable diseases, if treated from the economic point of view, may be characterised by high level of positive externalities. Positive externalities (side products of consumption) arise when one person benefits from another person's consumption without participation in costs.[133] An academic example of externalities in health care refers to the use of vaccinations, since they minimise the risk of infections also among non-vaccinated persons.[134] Surveys indicate that the use of insecticide-treated mosquito nets in some African villages influenced malaria morbidity also among people who did not use them.[135] On the other hand, public information campaigns on HIV/AIDS or condom use promotion are close to the model of public goods – every person may benefit from them and it is almost impossible to exclude selected people from participation in benefits. The state should be highly interested in financing activities leading to occurrence of positive externalities or having features of public goods, since handling communicable diseases through preventive measures consist in approaching groups and communities rather than individuals.

2.3 *HIV/AIDS Pandemic*

From all communicable diseases that affect South African states the HIV/AIDS pandemic merits a closer analysis for the impact it has on national economies and productivity of single households. According to data presented in the *World Health Report 2004* by the World Health Organization, 34 – 46 million people

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[132] *Ibidem*, p. 120.
[133] D. Begg, S. Fisher, R. Dornbusch, *supra* note , pp. 219 – 222.
[134] M. Green, *supra* note, p. 48.
[135] *Macroeconomics and health*, *supra* note, p. 28.

worldwide are infected with this lethal virus.[136] HIV/AIDS pandemic is a global issue, which affects all parts of the world, however its most explosive growth has been observed in developing countries. Two thirds of all infected people live in Sub-Saharan Africa, one fifth in Asia.[137] In some countries situation is more than dramatic. In Botswana HIV prevalence in population in productive age (15 – 49 years old) amounts to 37%. In Lesotho, Namibia and Zimbabwe it exceeds 20%.

The relationship between HIV/AIDS and economy is well established although in many cases underestimated. In the early analyses of the topic, impact of the HIV/AIDS pandemic on national economies was assessed to be similar to effects of one-time economic shocks such as natural disasters or collapses of global market. Economists assumed that destruction of labour force caused by HIV/AIDS would coerce more efficient use of other resources. They predicted that national economies would switch from labour-intensive production processes to more land- and capital-intensive technologies. The overall raise in labour productivity was supposed to be caused by relative growth of land and capital per worker.[138]

This assumptions and forecasts turned out to be false and based on misinterpretation of facts. As a matter of fact, HIV/AIDS resulted in descent of GPD by more than 1% in some countries, however its disastrous impact on national economy is much broader. Since the HIV/AIDS pandemic prevents children from enrolment in schools, it results in decrease of prospective future earnings. In the microeconomic scale of a single household, HIV/AIDS causes shift of resources from other purposes such as education or housing to health care.

As mentioned above, the most efficient way to counteract a pandemic is through prevention, which in case of HIV/AIDS takes form of: promotion of condom use, promotion of voluntary testing, counselling for HIV issues, promotion of delayed sexual initiation, etc.[139] A very important issue refers to the problem of HIV transmission from mother to child, which in developed countries affects 14 – 25% of children born of infected mothers, whereas in developing countries it reaches 42%.[140]

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[136] *The World Health Report 2004, supra* note, p. 1.
[137] *Ibidem.*
[138] *Ibidem*, p. 9 – 10.
[139] *Ibidem*, p. 12.
[140] *Ibidem*, p. 13.

This problem may be addressed by overall improvement of sanitation as well as change in breast-feeding practices.

Most of the measures preventing HIV/AIDS proliferation have features of public goods or may be characterised by high level of positive externalities, therefore they require state intervention. Public goods as well as commodities characterised by positive externalities are not suitable to be traded in free market. Success of information campaigns is limited, when recipients have to pay for information obtained. On the other hand, individuals, especially in low-income economies, do not want to incur costs of positive externalities arising from their consumption.

2.4 Malnutrition

Amartya Sen qualified extensive hunger to the worst and terrible happenings of the contemporary age.[141] Undernutrition is one of the most visible characteristics of economic underdevelopment. Whereas the industrialised countries coup with the problems of obesity, overweight and their impact on health, people in least-developed countries still suffer from hunger. Average prevalence of undernourishment worldwide amounts to 16%, this indicator grows in case of low-income countries and reaches 25% of their population. In terms of regions, the statistics are opened by Sub-Saharan Africa, where 32% of people remain undernourished. Dramatic situation has been observed in countries like Burundi, Democratic Republic of Congo and Sierra Leone, where prevalence reached or exceeded 50%.[142] In low-income economies, there is an evident connection between poverty and problem of nutrition. Nevertheless, the situation is also influenced by environmental factors such as climate and occurrence of natural disasters.

Malnutrition has an essential impact on demand for health care. It seems to be obvious that malnutrition increases overall susceptibility to diseases, thus it augment people's needs in relation to health care. On the other hand, hunger hinders increase in expenditures of households. A family, which suffer from malnutrition, has to reduce its disbursements on goods other than food. Similar to health care, food in the poorest countries belongs to the group of most essential necessities, therefore demand for

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[141] A. Sen, *Development as freedom,* Oxford Unversity Press, 1999, p. 204.
[142] All statistical data refer to years 2000 – 2002 and are taken from *World Development Indicators 2005, supra* note.

nutrition may be characterised by feature of inelasticity. Accordingly, health care and food are rivals in competition for resources.[143]

Undernourishment has a negative impact on productivity of households. Likewise diseases, it causes decrease in work capacity and overall income of a household, therefore it has negative impact on future earnings of households and situation of whole national economy.[144]

3. Relationship between Health and Economy

Relationship between health and economy is not of one-way nature. Certainly, a large part of health problems in developing countries is caused by inadequate state of their economies and general poverty. Industrialisation and urbanisation in developed countries contributes to rise of occupational diseases, accidents, and pollution. Surprisingly, urbanisation in poorest countries leads to increase of incidence of communicable diseases, since the cities are not able to provide their inhabitants with basic services such as sewage system, potable water, waste disposal, etc.[145]

On the other hand, health constitutes an important component of human capital. As mentioned above, health may be considered both as a consumption and a productive good however, in developing countries the role of health as important determinant of labour productivity and thus of human resources prevails. Since developing countries are lacking access to new technologies and other necessary resources (including capital and land), large part of production has labour-intensive character; therefore epidemics have large impact on national economies.[146]

In an indirect way, health problems hinder economic growth. They reduce the overall potential of households and thus of the potential of national economy. Children affected by diseases in early years have limited chances do obtain education or develop social skills. As mentioned above, people in low-income countries have

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[143] This statement refers equally to other necessities such as housing however, relationship between nutrition and health makes malnutrition merits a closer look..

[144] More detailed analysis in: D. Ray, *supra* note, p. 275 – 279.

[145] D.R. Phillips, Y. Verhasselt, *Introduction: Health and Development,* in D.R. Phillips, Y. Verhasselt (Eds), *Health and Development*, London – New York, Routledge 1994, pp. 6 – 10.

[146] J.R. Behrman, *Health and economic growth: theory, evidence and policy,* in *Macroeconomic environment and Health. With case studies for countries in greatest need,* World Health Organization, Geneva, 1993, pp. 21 – 23.

shorter life expectancy as well as healthy life expectancy (HALE), what considerably reduces their capacity to earn and consequently their total life-time earnings. This mean, in the microeconomics of a single household, that children have to start working earlier than their colleagues in developed countries, since their parents cannot support them financially for a longer period of time. In the scale of national economy, weak health makes investments in human resources difficult. The costs of schooling and education are partially or fully covered by the states. Education of high level specialists is also time consuming but productivity of educated people is limited by the short healthy life expectancy, thus the state authorities are forced to educate more and more people to satisfy the market needs and keep the economy growing.

Health and health care are major factors determining economic growth in least-developed countries. Private sector investments require labour force, which remains dependent on state investments in health care and education. On the other hand, epidemics and other health problems hit directly some branches of industry (such as tourism) or prevent foreign investors from entering local markets.

In order to summarize, it needs to be emphasised that demand for health care is determined by many factors such as price, wages, availability of medical services, level of education, consumption of other goods and necessities, etc. Nevertheless, demand is always limited by overall income of a household, which in a great part is determined by health of its members.

4. Economic Incentives

Economic incentives include measures aiming to improve efficiency in resource allocation. As policy tools, they might be directed to the service providers or recipients in order to make them act more economically. If applied on the demand side, they take a form of financial measures, such as user fees, imposing on patients, participation in the costs of medical care.[147]

User fees may be introduced to charge beneficiaries of public health systems in order to recover some of the costs of services provided. They are supposed to reduce the financial engagement of the state in health care and to augment quality of medical services. From the economic point of view, user fees introduce some element of market into state governed economy, since they correspond to the category of

[147] Liu, *supra* note, p. 53.

price. Since they increase overall costs of health care that individuals have to incur, they reduce number of unnecessary treatments or services by eliminating visits to health care points or purchase of drugs in cases, which could be resolved by other means.

Although user fees belong to typical policy tools used in developed countries, there were also attempts to introduce them in middle- and low- income countries. User fees have to be approached with great caution, since they create threats that might exceed benefits stemming from their application. It is argued that in developing countries introduction of user fees may lead to two major adverse side-effects: (1) decrease in overall use of medical services especially among vulnerable groups of population and (2) it may encourage providers of medical care to impose on patients unnecessary treatments (what leads to the negation of user fees objectives).

Ad. (1) Demand on medical services is inelastic, hence many economists assume that introduction of user fees would not affect negatively justified consumption of health care even in developing countries. However, empirical studies show that imposition of obligatory fees caused significant decrease in the use of health care including necessary and basic treatments (in Tanzania by 50%, in Kenya by 38%).[148] These adverse effects may be avoided, if the system of health care ensures increase in the quality of medical services in return for fees paid and at the same time appropriate support for the poorest and vulnerable (in form of exemptions or reimbursements).[149] Surveys performed in Benin, Sierra Leone, Guinea and Cameroon show that visible improvement in the quality was appreciated by patients and led to the increase in use of medical care rather than fall.[150] State authorities have to ensure that the financial means collected by charging patients for medical services are utilised to improve their quality and not wasted (e.g. used to finance administration of collected resources).

AD. (2) A risk of provision of unnecessary treatments exists, when the financial resources gained by the fees collection are managed and accumulated by the same entity, which delivers medical services. In order to avoid such situation, state authorities need to introduce an appropriate system of redistribution including incentives for service providers.

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[148] *Ibidem.*
[149] In this case discrimination of patients based on their incomes seems to be justified.
[150] Liu, *supra* note, p. 54.

A decision whether to introduce user fees or not has to be taken with the highest caution, since the advantages of introducing of such a system may not compensate the total costs. It has to be emphasised that introduction and maintenance of user fees impose on health care providers or state authorities additional costs related to collection of fees and administration of collected resources. These costs may consume large percentage of the revenue. On the other hand, inelasticity of demand for health care may cause that households, which have to cover higher costs of medical care will reduce their expenditures on other necessary goods such as education, housing or food. Other negative effects of user fees that have to be considered by decision-makers include change in people's attitude towards health and health care. Governments and international organisations spend millions on information campaigns aiming to convince individuals in developing countries to more health-oriented behaviours, which in many cases include elements new to their cultures. User fees may destroy effects of these campaigns.

Chapter 4 Overview of Main Determinants of Health Care Provision

Balancing health needs against resources is a challenge for decision makers in all countries since the resources are relative scarce to needs, even in the most developed countries. Developing countries, however, carry additional burden of underdevelopment that augment the distance between the needs, local capabilities and resources. Accessible alternatives lie far behind of what is desired in health care.

1. Availability of Resources

1.1 Classification of Resources

The question of resources lies at the heart of the problem in realising the right to health. Article 2 of the CESCR requires States to devote "maximum of their available resources" to realising the recognized rights. This provision situates the Covenant in its broader economic context, however usefulness of this provision as a measuring tool of state compliance with the Covenant is rather problematic. The macroeconomic parameters of the notion of "available resources" have not been sufficiently analysed, although their complexity and implications for the performance of States parties in the Covenant implementation play enormous role.[151] The questions of the "resource" definition, potential availability of resources to a state and the amounts of resources that should be devoted to realising socio-economic rights, including the right to health, have not been sufficiently answered. It has to be stressed that these questions are not easy to answer but yet are important for elucidating macroeconomic dimension of notion of "available resources". Provision of resources determines the process of "taking steps".

It is impossible to generate a definite list of the types of resources that s state might have access to, since the economic and social evolution creates continuously new resource needs. None the less, there are several categories of resources, which are vital for the individual's subsistence and human rights. After Robert Robertson the most important resources in achieving CESCR rights can be categorised as financial, natural, human, informational and technology-related.[152] A resources classification, adopted by Robertson, generally reflects a typology of resources existing in

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[151] Dowell-Jones, *supra* note, pp. 11-33.
[152] Robertson, *supra* note, pp. 695-697.

economics. Natural resources would represent land, human resources apply to labour in economics and all the others (financial, technology, information) refer to the capital, as a product of human activity.

The role of technology in realising health rights should not be underestimated. Employment of technology in such areas as medicine, building construction, communications, farming clearly proves its fundamental importance for ensuring social and economic well-being. Specifically, health care technology encompasses drugs, devices, medical and surgical procedures in health care, and organisational and supportive systems of health care provision.[153] Health economists estimate that the increasing development and use of the newest medical technologies are the main cause for the rise in health care expenditures, which in the cost of hospital care make almost 50%.[154] There are at least two reasons in favour of regulating health technologies market: one is related to the effectiveness and efficiency of health care provision, the other concerns the services that are too costly and have uncertain effect on health outcomes. Therefore health-related technologies should be treated with particular caution and subjected to regulation and control regarding their efficacy, safety, and cost-effectiveness before they are allowed into health care markets. The choices made in health care technologies market affects directly the mix of health interventions. Adoption of technologies in the absence of their evaluation and their over-supply are the most common reasons behind non-effectiveness of technologies in health care provision. It has been noticed that new costly medical technologies are used even when an equally effective and lower-cost technology is available. It has certain implications on the balance of medical services supply in health care system because using costly and ineffective technologies might hinder the provision of such services to everyone in need on the basis of equality. The governments are mandated to require delivery of information on efficacy, safety and cost-effectiveness of medical technologies with purpose of their proper evaluation and decision on the introduction into the official market. Technology assessment is the prerequisite for technology control and very important factor for the choice of health interventions since it influences government permission for entry into the market and providers of health interventions. Effectiveness of technology control is dependent on the

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[153] Liu, *supra* note, p. 17.
[154] *Ibidem.*

obtainment of profound and weighty information through the process of technology assessment. It is quite common that governments fail to control the adoption of unacceptable technologies due to lack of information or failure in its proper utilisation. This proves only how important the information is as a resource in health care. Most low- and middle-income countries do not bother to undertake a valid evaluation of new medical products and if they do, they concentrate on data referring to efficacy and safety without any attention put on cost-effectiveness.[155] The adoption and use of a new technology based only on efficacy without considering the costs, might of course improve health outcomes, but not necessarily in a cost-effective way.

Information as a resource cannot be quantified; therefore its qualitative features are taken into account in the measuring states compliance with the CESCR. Much of crucial information is within the control of the state e.g. results of drug tests conducted by government or impact of a large hydroelectric project and may be critical for people to protect their own health. There are certain requirements in respect to the information products disseminated by governments and they include the following: comprehensiveness of the information content, usefulness of the information for realising a given right, accessibility of the information and appropriateness of its presentation for the purpose of its full use.[156] Information is the most important resource in the process of setting priorities in health care as it requires enormous amounts of information such as epidemiological data, disease patterns, utilisation of health care facilities among different societal groups. Priorities based on the wrong data input may have a negative impact on health of the whole population.

The fundamental question arises: what resources can be potentially mobilised and used for the purpose of realisation of the right to health. It would be unrealistic to think that a state could devote all potential resources to fulfilling the Covenant rights only. The availability of resources cannot be automatically measured by government expenditures and financial reserves of the state should not be treated as a surplus in government accounts that can be transferred to funding e.g. social security scheme or health care system. States are very often incapable of fulfilling socio-economic rights out of their own funds, therefore they should create conditions that would allow the use of private resources and encourage people's movements, campaigns and

[155] *Ibidem*, p. 18.
[156] Robertson, *supra* note, p. 706.

initiatives aimed at satisfying citizens' needs.[157] When determining strategies for the fulfilment of the right to health, States are obliged to consider not only all domestic resources over which they exercise direct control but also all the international resources left at their disposal.[158]

1.2 Allocation of Resources and Cost-Effectiveness

Improvement of allocative efficiency in health care requires setting an ideal plan, which presumes that resources are allocated in an optimal way. The next step in this approach consists of examination of the potential, most feasible policy tools that will enable progress in pursuance towards the ideal goals of the plan. Achievement of objectives in the health system (i.e. health status of the population) is not the only concern of decision-makers. As scarce resources are used to produce the most cost-effective interventions, the costs at which such interventions are produced have to be taken into account. The concept of allocative efficiency regards health interventions, defined as all services, activities and medical products aiming to improve health, as inputs and health of the population as an output.[159] Allocation is considered to be effective when the health outcome has been maximised by the least costly combination of health interventions. In practical terms cost-effectiveness of health interventions requires providers to create a combination of health interventions reflecting people's needs and to deliver them at the least location to those who need them most and can obtain the highest health gain. Allocative efficiency of health interventions means simply the right health care to the right people at the right place.[160] Allocative efficiency of the whole health system could be improved by transferring resources from cost-ineffective interventions to cost-effective ones. It has been a recent development to combine cost calculations with measures of interventions effectiveness to determine priorities in health care provision.

It has to be stressed, however, that cost-effectiveness is relevant for achieving the best overall health, but does not necessarily would reduce inequality. Populations with worse health than average are not that responsive to certain interventions or it costs more to reach them.

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[157] *Ibidem*, pp. 698-699.
[158] *Ibidem.*
[159] Liu, *supra* note, p. 5.
[160] *Ibidem.*

1.3 *Balancing the Mix of Resources*

The process of health care provision involves combining a significant number of resource inputs in order to deliver a range of various service outputs that simply are defined as production of health interventions. Three major health system inputs can be identified: human resources, physical capital, and consumables.[161] All these inputs need financial resources in order to be purchased, in the form of capital investment as well as of recurrent character. Capital is the stock of productive assets such as health workers, medical equipment, hospitals etc. Educating more medical staff and purchasing equipment are examples of investments in the stock of capital. The productive lifetime of such investments vary from one to thirty years or more depending on the type of capital and is influenced mostly by technological progress and proper/improper maintenance. Improper maintenance and poor management are major determinants of health capital deterioration. Human capital is similar in this respect to physical capital although knowledge does not deteriorate with use. None the less, skills become obsolete with introduction of new technologies, therefore human capital needs to be maintained too. In consequence, financial resources can either take form of one-time capital investment or long-term recurrent financing.

Investments are tools for adjusting capital stock and creating new productive assets. Investment levels differ substantially between developed and developing countries. For instance, expenditures for investments in buildings and equipment do not use more than 5% of total annual health care budget in OECD countries.[162] In turn, low-income countries such as Cambodia, Kenya, and Mali spend forty to 50% of total public health care budget on physical infrastructure.[163] Health care staff and consumables are paid from the remaining recurrent budget, which indicates clearly that only a very small fraction of total expenses is devoted to maintenance of physical and human capital. Additionally, decision-makers in less developed countries are often tempted to accept donor aid irrespective of its long-term impact on the balance among existing resources or between investments and recurrent costs. In result, public budgets are not able to collect sufficient money in order to cover further maintenance and operational (recurrent) costs of such investment. Decision-makers are left then

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[161] *The World Health Report 2000. Health Systems: Improving Performance* , Geneva, WHO, 2000, p. 75.
[162] *Ibidem*, p. 76.
[163] *Ibidem.*

with two options; they either shift financial resources from other activities or leave donor investment without necessary maintenance for years leading often to the waste of donor aid. However, only donors can be blamed for their short-term thinking and focusing on rather visible investments. Lack of available data in low-income countries on the size and kind of annual investments in both public and private sector makes it the more difficult to compare capital decisions and recurrent costs and guarantee that capital is not wasted.

Human resources, such as doctors, nurses and health administration workers are vital part of all health care systems. Their knowledge, skills and motivation influence greatly the performance of the whole health care system and costs of their employment consume the biggest part of the health recurrent budget. But health specialists would not be able to provide services without physical capital in form of hospitals, medical equipment and consumables, such as medicines. The two latter inputs are important for raising the productivity of human capital. Shortages of essential medicines and other consumables together with insufficient facilities and inadequate pay result in poor working conditions that in less developed countries have very negative impact on staff motivation. There are several reasons such as poor level of income, lack of financial incentives, and no possibilities for professional development that force health workers to look for additional sources of satisfaction and income. The most common opportunity to supplement a regular income for health care specialists is to use public facilities (e.g. medical equipment in hospitals) for private practising (private health care). The situations in which doctors and nurses accept "informal payments" are not uncommon in less developed countries or those countries in transition. This creates great inequalities in access to health care because at the end of the day only those who can afford to pay a physician informally will be medically treated. It happens very often that physicians accepting informal payments use in their treatment equipment that is funded from public financial resources. In this way they add up to the use up of hospital equipment but do not contribute financially to its maintenance. "Informal payments" are not subject to taxation thereby income of a public budget, out of which also public health care is financed, is lessened. Additionally, such practice is not only economically but also socially harmful since people quickly get used to the existing conditions and physicians in order to earn more might offer treatments that are not necessarily needed or cost-effective. Human

resources are also severely affected by management and different, very often legally authorised, incentives for providers that might not necessarily lead to cost-effective health care provision. Physicians in Bangladesh are obviously interested in expanding the volume of laboratory services since they get 30 to 40% of charge for every referral and physicians in Poland supplement their income "informally" by prescribing branded drugs instead of generics, for which they are generously rewarded by pharmaceutical producers.[164]

Human capital is the most important out of health system's inputs therefore careful attention should be paid to their development. Human skills markets do not respond immediately to market signals and they need more time to adapt to new conditions just as it takes years to educate a next generation of health workforce. In order to adjust to new conditions, first signals from the market about some discrepancies in the resource distribution should be considered and analysed immediately in order to ensure future balance. The exact norms regarding the right ration of physicians or nurses to population do not exist and shortages or oversupply are evaluated on the basis of need, priorities and comparisons to countries of similar developmental level. Different strategies might be implemented to deal with problems of human resources availability and proper distribution of health services they offer. One of them is efficient use of available personnel through better geographical distribution since it has been universally proved that providers tend to concentrate in urban areas, leaving rural areas understaffed. There are many striking examples of countries where unequal and completely inappropriate collocation of health professionals takes place e.g. Angola where 65% of the population live in rural areas, but 80% of health staff is employed in urban areas.[165] In less developed countries, where infrastructure such as roads or public transport leaves much to be desired, it is additional hardship for rural dwellers to obtain medical care. Some countries, like Canada and Norway, introduced mandatory service and financial, educational and other incentives to make unattractive areas more appealing.[166] Other strategies could include greater use of multiskilled staff where appropriate and ensuring close match

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[164] *The World Health Report* , *supra* note, p. 79 (Bangladesh example); Example from Poland supported by personal experience, common knowledge and so called "journalists' investigations" for the main Polish newspapers.
[165] *Ibidem*, p. 79.
[166] *Ibidem*, p. 80.

of skills and functions. For the purpose of appropriate health service there is a need for some kind of degree of flexibility in substitution among different types of human resource inputs while preserving a constant quality level of health output. Many countries face shortages in qualified health personnel (in sub-Saharan Africa) or a mismatch between available skills and the needs and priorities of the health care system (Eastern Europe). The former is caused, *inter alia*, by the brain drain of trained staff from low-income countries to wealthier countries or from the public sector to the private sector within a country. More successful physicians emigrate, in search for higher standards of practice and better remuneration and overseas students from poor countries may wish to stay in the country where they were trained when such an opportunity is opened for them. The latter problem can be tackled through long-term strategy of reorientation of health specialists through limiting admissions to certain trainings or substitution for other health professionals.

Imbalances among the resource inputs might have negative impact on the health outcome, therefore for the purpose of achieving a sustainable balance among different sorts of resources and between investments and fixed costs it is necessary to identify appropriately health needs, social priorities and people's expectations.[167] Health care systems must direct investments in human capital in such a way that they cover not only present demands but also future needs and available resources. Perhaps the most important incentives in the human capital investments would be improved salaries, better career opportunities and working conditions. What has to be born in mind is that health care staff is not motivated only by present conditions but also by the future prospects, which can be concluded from past experiences or current trends in a health care system. Low morale among qualified staff results in a lower performance.

2. Priority Setting and Social Context

Priority setting in health care is an unquestioned challenge that in all underdeveloped and most developing countries grows into a considerable dilemma. While selecting priorities in health sector, one has to take into account a range of parameters, including social, cultural, economic and political. Identification of major health problems and determination of their magnitude for various population sections

[167] *Ibidem*, p. 77-79.

are the first and primary steps of priority-setting approach.[168] Allocation of the scarce resources should be based on the clear determination of goals, objectives, targets and standards of the planned action. Beforehand it is necessary, however, to make a detailed assessment of the health problems and their magnitude, feasibility of such a priority set, including costs, and probable impact of interventions. There is no unilateral answer to the question of what should be the priorities in health care. Single value adjudications will vary according to the individuals and groups involved. Likewise, priority settings in developed countries will differ from those in developing countries because problems and their scale, as well as methods used to tackle them are of dissent nature. Public participation and debate on legitimate priorities in given circumstances is of particular relevance to the priority-setting processes. Citizens and other actors, involved in the health care provision, have to give their consent to the potentially used methods.[169] John Bryant describes the results of an experimental primary health care (PHC) programme that clearly exemplifies the importance of both, community participation in health care improvement and socially sensitive research approaches in addressing inherently health problems (priorities).[170] After developing and implementing a community-based PHC programme in the poor squatter settlements of Karachi, Infant Mortality Rate (IMR) decreased from 126 to 60 over a period of five years. However, the IMR stayed at this level and did not continue to diminish. Discussions with the community and additional analysis of those households resistant to the usual PHC approaches revealed the existence of supplementary risk factors (illiteracy of mothers, lack of cultural autonomy of mothers for child care decisions), of which the researchers from the Aga Khan University were not aware.[171] The assistance of the community, which effectively discussed the issues of maternal autonomy or adequate childcare and played an intermediary role between the health team and "resistant" households, was indispensable.

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[168] John H. Bryant, *Health Priority Dilemmas in Developing Countries* , in Angela Coulter, Chris Ham (Eds.), *The Global Challenge of Health Care Rationing*, Buckingham, Open University Press, 2001, p. 63.
[169] *Ibidem*, p. 65.
[170] *Ibidem*, pp. 67-69.
[171] *Ibidem*, pp. 68-69.

There is certainly a relationship between health status and the level of "disorganisation" of a society.[172] It is arguable, however, that the latter can be convincingly considered as the most significant determinant of health of the vulnerable. None the less, improvements in health care should head towards not only technical interventions but also building partnerships with the marginalised people. The vulnerable become a driving force of changes in their own social environment, therefore participatory approach to building local capacities might be a panacea for local problems. The explanation behind the participatory concept is that individual's health is tied to the wider conditions of life and cannot be separated from political and social concerns. The social context reality of the vulnerable includes both physical/biological conditions of the aforementioned, but also their position society. The concept *condition-and-position* can be easily translated into another idea of *practical-and-strategic* needs.[173] Considering, for example, women's health it is assumed that their practical needs (need for water supply, credit schemes, seeds) can be addressed by short-term development interventions though aspects of inequality in gender relations would not be eliminated. Notwithstanding, women's strategic needs include changing their subordinate position to men, through e.g. ensuring access to decision-making power, eliminating discrimination in areas of labour, land ownership and education. This example proves that in order to improve health of the vulnerable, it is not enough to concentrate on the quality of services but it is essential to introduce structural changes in the social environment that in long-term will sustain. Developing and underdeveloped countries are characterised by the persistence in dealing with health issues without considering the social context in which they must operate. The result of such inappropriate policies is that they fail to meet their objectives. Therefore, determination of strategies that are likely to be effective in overcoming the problems must be based on two conditions: agreement on the priority area for social change and a common language of discourse for meaningful analysis of strategies and plan of actions.[174]

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[172] Kausar S. Khan, *Public Health Priorities and the Social Determinants of Ill Health* , in Angela Coulter, Chris Ham (Eds.), *The Global Challenge of Health Care Rationing*, Buckingham, Open University Press, 2001, p. 74

[173] *Ibidem*, p. 76.

[174] *Ibidem*, p. 80.

3. Health Care System and its Functions

Attainment and performance are two terms that are inextricably linked with health systems. The former is related to the achievement of *objectives* of good health, responsiveness and fair financial contribution, the latter is concerned with the question whether the system could perform better with the same resources.[175] Health systems are influenced by so many factors that lie outside of their control or administration such as income distribution or climate, that evaluation of their progress in realising the aforementioned goals should be placed in the context of reality (what realistically can be achieved). The principal objective of a heath system is to improve people's health (good/better health) and its main function is to deliver health services that will serve the attainment of better health. This goal is unique for this system but other systems, though holding other objectives, might greatly contribute to the achievement of better health (education system, system of public finances, social security system). The other two complementary objectives of health system, mainly responsiveness and fair financing, are common to other social systems but differ from them at least in two ways. One is that health care can be very costly and the need for it is unpredictable, the other relates to implications of illness and medical care on people's dignity and autonomy. Responsiveness is about assuring that people's expectations to their physical and psychological treatment are considered. It might happen that the health outcomes are satisfactory but people are still unhappy with the system (e.g. poor people or rural populations treated with less respect for their dignity, having less choice of providers). Fair distribution of financing burden may contribute to better health e.g. by reducing the risk of non-availability of care for those who need it but cannot afford it. In principle, fair financing in health systems implies financial protection for everyone, which means that the risks of households related to the costs of the health system are distributed using criteria of ability to pay than to the risk of illness. In most low-income countries, in which at least part of the population is not protected from financial risks, the whole households, not only individuals, are forced into poverty in result of medical care purchase, or do not receive care because of the too high costs. Out-of-pocket financing of the system is an example of an unfair distribution since it prevents the most vulnerable from utilising

[175] The World Health Report, *supra* note, p. 23.

medical care (they cannot afford it) or impoverish them more if they decide to pay for medical services, shifting their scarce resources from other crucial purchases (e.g. food). It is estimated that families that spend 50% or more of their non-food expenditure on health are more likely to be impoverished in result of out-of-pocket spending. Financial fairness is better achieved by introducing pre-payment in place of out-of-pocket expenditure.

Studying health system performance is about measuring its achievements and exploring how the system functions in order to achieve objectives. Health system is a quite complicated apparatus, which performs many functions with the purpose to achieve its main goal, health. Four key functions can be identified, namely stewardship, financing, creating resources and services delivery.[176] Both, functions and objectives are interrelated; some of them are economically related. The truth is that unless these functions are properly carried out, the health outcome may be poor therefore they are called also determinants of heath system performance.

4. Health System Financing

"Getting what you pay for" is perhaps fair rule in market transactions, however seems to be less fair when it comes to health care financing. Some additional mechanisms are needed in order to ensure that also those who are unable to pay have equal rights to be healthy and equal access to medical help in case of illness.

Expenditures in health care have risen from 3% of world GDP in 1948 to 10% in 2002.[177] With this significant change societies are faced with new challenges in searching for a such health care financing which would assure accessibility of health care to everyone, no matter whether one can afford it or not. The main function of the health system is to provide health services to the population and health financing plays the key role in interactions between providers and health care beneficiaries. Making funding available and creating financial incentives for providers so that all individuals have access to health care, are the main purposes of health financing. Financial incentives for providers are used to motivate them to increase health and improve responsiveness of the system. An inadequate health financing leads to situations when right-to-health-holders are unable to pay for health care services or

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[176] *Ibidem*, p. 24.
[177] Word Bank, *World Development Indicators 2005*, *supra* note.

will be impoverished in result of using it. There are three crucial tasks that a health system financing performs: revenue collection, pooling of resources, and purchasing of interventions with the purpose of health services delivery[178] They are all interrelated and can be integrated in a single organisation managing health care but new trends show that a separation between financing and provision may be introduced.

Revenue collection is defined as a process in which health system obtains the necessary financial resources from households, organisations, companies, and donors.[179] There are many different ways for the health system to collect revenue, such as general taxation, mandated social health insurance contributions, voluntary private health insurance contributions, out-of-pocket payments, and donations. Most developed countries rely on either general taxation or mandated social health insurance contributions, some high income countries introduced a mixed financing system, based on both mandatory social contributions and voluntary private health insurance contributions. Developing countries in contrast depend heavily on out-of-pocket financing, which may constitute there up to 100% of all private expenditures on health.[180] Another feature of health system budget in developing countries

Pooling has an insurance function within the health system, which main objective is to share the financial risk related to health interventions for which the need is uncertain. Revenues have to be accumulated and managed in such a way as to ensure that the risk of compulsory payment for health care is borne by all members of the pool and not by each contributing individual. Pooling increases and stabilises demand and the flow of funds. Patients are more likely to afford services and providers are more secured. Health system policy should focus on pooling needs and secure conditions for the development of larger pooling arrangements. In low-income countries, even small pools or pools some segments of the population are better that out-of-pocket financing because they ensure better protection of health consumers. Out-of-pocket payments have the highest degree of fragmentation; each individual is a pool himself/herself and has to pay for his/her own services. The majority of health systems combine pooling and government subsidy for spreading the risk and cross-subsidisation of income. Members of pools have different risks and income profiles

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[178] *The World Health Report 2000*, *supra* note, p. 95.
[179] *Ibidem.*
[180] *World Health Report 2004*, *supra* note, pp. 136-143.

what allows for better equity in health services usage. It is advised that decentralisation within pool organisations should always be accompanied by equalisation and compensatory mechanisms for resource allocation to reduce the risk of only low-risk selection and in result exclusion of poor and sick from pools. Moreover, wasteful and careless collecting and pooling revenues reduce the funds available for health services and investments and also diminish people's access to the services that could be system-financed.

After the funds are collected and pooled, the next step in financing occurs – purchasing. Through the process of purchasing providers are paid for delivery of a specified or unspecified set of health interventions. There are two kinds of purchasing; passive purchasing follows a predetermined budget or pays for presented bills, strategic purchasing searches constantly for optimal ways to maximise health system performance through active participation in choosing interventions (selective contracting, incentive schemes). There are two major categories of essential interventions: essential package of services and an essential drug list, combining all other medical products different from services and activities included in the package of services. Public health interventions usually are of preventive character and are directed to entire populations (e.g. immunisation), in contrast clinical interventions represent care and are addressed to individuals. In some poorest countries of the world, the coverage of many basic interventions is falling, not rising. Purchasing influences both, equity and efficiency in health care system, therefore its actions should be wisely chosen, on the basis of estimated health improvements and people's expectations and needs.

The share of prepayment on total spending determines fairness of a health system financing. Out-of-pocket payments are considered the most regressive way to pay for health and in most cases expose poor people to greater financial risks or deprive them of health care access. As regards health financing in developing countries, the discussion about impact of public versus private financing on health system outcomes should rather shift to the relevance of prepayment and out-of-pocket spending to their respective needs. It is predominantly dependant on policy-makers how public financing is organised and how they influence private financing in health care. It is particularly important as both tasks are not easy but have colossal impact on determinants of health system financing performance, such as the level of

prepayment, the degree of spreading risk, subsidising poor and strategic purchasing. While paying out-of-pocket for health services at the moment of seeking treatment excludes the poorest members of society in health care, prepayment serves spreading the financial risk among all members of a pool. Revenue collection mechanisms determine the level of prepayment, e.g. general taxation allows for maximum separation between contributions and utilisation. Why then out-of-pocket payments are used particularly in developing countries? The answer is related to the institutional and organisational capacity within those countries. Separation of contributions from utilisation requires strong institutional and organisational capacity of the institutions responsible for collection of contributions, which are lacking in low-income countries. For instance, general taxation (main source of receipts in a health system budget) requires an excellent tax/contribution collecting capacity and is mainly associated with a formal economy, whereas in developing countries the informal sector often is dominant. In low-income countries (less than $760 per capita) general taxation on average accounts to 14% of GDP, whereas in high-income countries it exceeds 30% of GDP.[181] Other types of prepayments, such as social security contributions and voluntary insurance, are easier to collect but again participation in social insurance schemes is available only to formal sector workers (contributions through salary deductions). Weak institutional capacity and high out-of-pocket expenditures force decision-makers to look for other possibilities to finance health, apart from general taxation and job-based contribution systems. Perhaps one of the possibilities would be introduction of "community financing" schemes but although they have been proved to be difficult to sustain, they may become transitional instruments to achieve higher level of pooling or improvement in targeting of public subsidies in health.[182] The idea behind such a community prepayment scheme is an incentive scheme, in which each 1$ raised by the community for prepaid health coverage would be additionally subsidised by the national government.[183] Such schemes in developing countries could also be backed by health-related donor assistance, which could act as guarantor for the community and help establish the necessary organisational and institutional capacity.[184]

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[181] *WHO CMH Report*, 2001, p. 59; available at http://w3.whosea.org/eip/tab70.htm.
[182] *The World Health Report 2000*, *supra* note, p. 98.
[183] *Macroeconomics and health*, *supra* note, p. 60.
[184] *The World Health Report*, *supra* note, pp. 136-143.

5. International Assistance and Health Care in Developing Countries

5.1 Role of International Assistance in Low-Income Economies

International aid constitutes a significant part of budgetary resources in developing countries. This statement may be illustrated by statistical data. In economies belonging to the group of middle-income countries aid dependency ratio represented by share in GNI amounts to 0.4% (in 2003; 0.5 in 1999), in low-income economies the same index reaches 3% (2.7 in 1999), whereas in the poorest region of the world – Sub-Saharan Africa, dependency ratio come to 6% t of GNI (4.7 in 1999). In least-developed countries dependency ratio fluctuates between 10 – 20%, in some cases exceeding 30% (in Burundi, Eritrea, Guinea-Bissau, Sierra Leone and Congo Democratic Republic).[185] Level of dependency in case of low-income economies is growing, whereas in middle-income countries the tendency is reverse. High level of dependency may be explained by a simple fact that the government, basing on national economy, is not able to fulfil the most important needs of the society. On the other hand, drastic and accidental increases in dependency index may be caused by local conflicts, civil wars, natural disasters, etc.

The reason for international assistance is based on a theory, according to which development aid should enable under-developed economies to take off and begin to grow. Truthfulness of this hypothesis remains questionable. It is argued that the reason, why financial assistance did not make developing economies blossom, is its limited size in comparison to needs, ineffective use and lack of appropriate policies addressing the problems of human capital.[186] On the other hand, needs of developing countries encompass not only shortage of financial resources but also lack of expertise and technology. The aforementioned hypothesis has also another adverse consequence. It makes decision makers conceive development aid as transitory and temporary measure rather than a long-term policy tool.

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[185] Statistical data come from *World Development Indicators 2005, supra* note.

[186] K. Tomasevski, *Development Aid and Human Rights,* Pinter Publishers, London, 1993, pp. 29 – 30.

5.2 *External Financing of Health Care*

One third of overall development aid is designed to support social services and social infrastructure including health care.[187] Countries, whose economies are characterised by the highest dependency ratio, have also the highest share of external resources in medical care financing. In low-income economies, this indicator usually exceeds 10% of total health care expenditures however, in some countries such as Burundi, Central African Republic, Ethiopia, Mozambique and Zambia it surpasses 30%. The highest level of foreign financing in health care exists in Eritrea (52 %), Timor (53 %), Liberia (59 %) and Chad (62 %).[188]

Governments aim to provide medical services to as many people as possible. This task is difficult to perform in low-income countries, since the revenue of public budget is not able to cover expenditures necessary to attain this goal. Since it is impossible to shift all national resources to health care sector, therefore even, if the governments of developing countries tend to increase health budgets, they are still far from reaching 8% of GDP recommended by WHO.[189] On the other hand, low incomes of households do not allow them to fill the gap between possibilities of the public budget and people's needs.

International assistance increases potential of the supply side on health care markets and thereby fulfils its major goal – introduction of balance between demand and available resources. In most countries external resources are used for investments however, in case of countries with greatest needs they may be utilised to cover operational costs of health care providers. On the other hand, international aid may have adverse effects on national economy. In longer term, it might lower people's activity and reduce efficiently in resource allocation.

5.3 Structural Adjustment Programmes and Health Care

Structural adjustment programmes are economic policies aiming to counteract adverse economic trends in least-developed countries by introducing elements of

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[187] *Ibidem*, p. 39.

[188] Statistical data refer to the year 2001 and are cited from *The World Health Report 2004*, *supra* note, pp. 136 – 143.

[189] Average health budget in countries of Sub-Saharan Africa amounts to 5%. See J. Perrot, *The place of external aid in the health sector in Chad,* in *Macroeconomic environment and Health. With case studies for countries in greatest need,* World Health Organization, Geneva, 1993, p. 165.

liberal economy in order to stimulate economic growth. They were planned to reform public budget in order to increase budgetary revenues and limit expenses.[190] Structural adjustment programmes were introduced with international assistance and supported by the International Monetary Fund and the World Bank. They aimed to reform currency policies, increase export, ensure long-term economic growth, and reduce budgetary deficit and inflation. Programs sponsored by the World Bank were created to reform certain sectors of economy, increase efficiency and flexibility of production.

Not all developing countries participated in structural adjustment programmes. Some African countries refused to participate in adjustment programs, some other were excluded due to a relative good shape of their economies and reasonable economic policies.

It is not easy to judge the impact adjustment programs had on economies, since it is hard to identify their direct effects. However, overall result of adjustment policies was unsatisfactory in short term. In most countries, adjustment programmes resulted in unemployment, decrease of income and economic growth as well as fall of investments. In many cases, budgetary cuts were not compensated by limited international aid. As a result of adjustment Cote d'Ivoire experienced a significant decline per capita GNP and augmentation of poverty by 4.8%.[191]

Structural adjustment had also very negative impact on health care. They affected mostly local clinics and thus provision of health services in rural areas, thereby increasing inequality in access to medical care. Reduction in real wages of medical staff resulted in outflow of educated and experienced personnel. In terms of efficiency and quality of services better performance was observed in countries that did not participate in adjustment programmes.[192]

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[190] J.K. Thiesen, *A Study of the Effects of Structural Adjustment on Education and Health in Africa*, in G.W. Shepherd, K.N.M. Sonko (Eds.) *Economic Justice in Africa. Adjustment and Sustainable Development*, Greenwood Press, 1994, pp. 80 – 81.
[191] *Ibidem*, p. 84.
[192] *Ibidem*, pp. 100 – 101.

Conclusion

As demonstrated in the first chapter of the thesis, the right to heath has been established as a human right in the international instruments. Texts of international treaties refer to two very important aspects of health care: they impose on states certain obligations in the sphere of health care and they emphasise the role of efficient use of available resources and thereby refer to the economic aspects of health care.

Leaving health care problems exclusively to the 'invisible hand' of free market without any state interference, provide a certain solution. However, it is easy to guess that this solution creates socially unacceptable effects such as exclusion of certain people from access to health services. Adverse consequences of the free market economy affect mostly vulnerable groups of people, which are subject to special care in international human rights law. Therefore, the governments are forced to undertake appropriate measures in order to ensure access to health services to as many people as possible.

Health care, likewise other spheres of human activity, is a subject to the laws of economics and is affected by the scarcity of resources. Consequently, economic phenomena like demand, supply and market failure exist also in the sphere of health care. Provision of health assistance requires efficient allocation of resources. Therefore, it is useful to explore economic incentives in health care as well as possible channels of distribution.

International law does not oblige governments to apply a specific system of allocation, however it is clear that both free market and totally commanded economy are neither suitable nor desirable as methods of heath care distribution. The first inevitably leads to unequal distribution; the latter may result in the emergence of black markets, which cause even broader adverse effects.

State intervention seems to be unavoidable in case of developing countries. Low purchasing force of the households and inelasticity of demand for medical care do not allow to transfer financial burden to the households. Accordingly, application of economic incentives may produce more adverse effects than positive results. In least-developed economies health belongs also to major determinants of economic growth and development, thereby setting limits to possibilities of enjoyment of other human rights. Since the state budgets in developing countries are not able to cover

health needs of the societies, a durable and continuous help from the international community seems to be indispensable.

Bibliography

1. Appleby J., *Economic perspectives on markets and health care,* in W. Ranade (Ed.), *Markets and health care: a comparative analysis,* Essex, Addison Wesley Longman, 1998.
2. Begg D., Fisher S., Dornbusch R., *Economics,* Seventh edition, London, McGraw-Hill, 2003.
3. Behrman J.R., *Health and economic growth: theory, evidence and policy,* in *Macroeconomic environment and Health. With case studies for countries in greatest need,* Geneva, World Health Organization, 1993.
4. Bryant J.H., *Health Priority Dilemmas in Developing Countries*, in Angela Coulter, Chris Ham (Eds.), *The Global Challenge of Health Care Rationing*, Buckingham, Open University Press, 2001.
5. CESCR, General Comment No. 14, *The right to the highest attainable standard of health (article 12 of the ICESCR)*, UN Doc. E/C.12/2000/4, 2000.
6. CESCR, *Poverty and the International Covenant on Economic, Social and Cultural Rights*, Statement adopted by the Committee on Economic, Social and Cultural Rights on 4 May 2001, E/C.12/2001/10, 2001.
7. Chapman A.R., *Core Obligations Related to the Right to Health*, in Audrey Chapman, Sage Russell (Eds.), *Core Obligations: Building a Framework for Economic, Social and Cultural Rights*, Antwerp, Oxford, New York, Intersentia, 2002.
8. Chapman A.R., Russell S., *Introduction*, in Audrey Chapman, Sage Russell (Eds.), *Core Obligations: Building a Framework for Economic, Social and Cultural Rights*, Antwerp, Oxford, New York, Intersentia, 2002.
9. Cheffins B.R., *Company law: theory, structure and operation,* Oxford University Press, 1997.
10. Commission on Macroeconomics and Health, *Macroeconomics and health: Investing in health for economic development,* J.D. Sachs (Chairman), Geneva, World Health Organization, 2001.
11. Craven M., *The International Covenant on Economic, Social and Cultural Rights*, in Raija Hanski and Markku Suksi (Eds.), *An Introduction to the International*

Protection of Human Rights, Turku/Abo, Institute for Human Rights, Abo Akademi University, 2004.

12. Craven M., *The International Covenant on Economic, Social, and Cultural Rights. A perspective on its Development*, Oxford, Clarendon Press, 1995.
13. Dowell-Jones M., *The Committee on Economic, Social and Cultural Rights: Assessing the Economic Deficit*, in «Human Rights Law Review», vol. 1, no. 1, 2001.
14. Drzewicki K., *Internationalization of Human Rights and Their Juridization*, in Raija Hanski and Markku Suksi (Eds.), *An Introduction to the International Protection of Human Rights*, Turku/Abo, Institute for Human Rights, Abo Akademi University, 2004.
15. Eide A., *Economic, Social and Cultural Rights as Human Rights*, in A. Eide, C. Krause and A. Rosas (Eds.), *Economic, Social and Cultural Rights. A Textbook*, Dordrecht/Boston/London, Martinus Nijhoff Publishers, 1995.
16. Frankel S., Ebrahim S., Smith G.D., *Limits to demand for health care,* in «British Medical Journal», vol. 321, 2000.
17. Goldberg P., *Women, Health and Human Rights*, in «Pace International Law Review», vol. 9, 1997
18. Green M., *The Economics of Health Care,* London, Office of Health Economics, e-source available at: www.oheschools .org.
19. Hopkins Tanne J., *Figures show more Americans do not have insurance,* in «British Medical Journal», vol. 329, 2004.
20. Hunt P., UN Commission on Human Rights, *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Report of the Special Rapporteur, E/CN.4/2004/49, 2004.
21. Jagers N., *Corporate Human Rights Obligations: in Search of Accountability*, Antwerpen, Intersentia, 2002.
22. Jamar S.D., *The International Human Right to Health*, in «Southern University Law Review», vol. 22(1), 1994.
23. Khan K.S., *Public Health Priorities and the Social Determinants of Ill Health*, in Angela Coulter, Chris Ham (Eds.), *The Global Challenge of Health Care Rationing*, Buckingham, Open University Press, 2001.

24. Kloos H., *The poorer Third World. Health and health care in areas that have yet to experience substantial development,* in D.R. Phillips, Y. Verhasselt (Eds), *Health and Development*, London – New York, Routledge 1994.
25. *Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights*, UN Doc. E/CN.4/1987/17, Annex, reprinted in «Human Rights Quarterly», vol. 9, 1987.
26. Liu X., *Policy tools for allocative efficiency of health services,* Geneva, World Health Organization, 2003.
27. *Maastricht Guidelines on Violations of Economic, Social and Cultural Rights*, Maastricht, January 22-26, 1997, in «Human Rights Quarterly», vol. 20, 1998.
28. McPake B., Kumaranayake L., Normand C., *Health economics: an international perspective,* London, New York, Routledge, 2002.
29. *Oxford Advanced Learner's Dictionary*, Oxford, Oxford University Press, 1995.
30. Perrot J., *The place of external aid in the health sector in Chad,* in *Macroeconomic environment and Health. With case studies for countries in greatest need,* Geneva, World Health Organization, 1993.
31. Phillips D.R., Verhasselt Y., *Introduction: Health and Development,* in D.R. Phillips, Y. Verhasselt (Eds), *Health and Development*, London – New York, Routledge 1994.
32. Ray D., *Development Economics,* Princeton, Princeton University Press, 1998.
33. Robertson R.E., *Measuring State Compliance with the Obligation to Devote the "Maximum Available Resources" to Realizing Economic, Social, and Cultural Rights*, in «Human Rights Quarterly», vol. 16, 1994.
34. Santerre R.E., Neun S.P., *Health economics: theories, insights and industry studies,* Chicago, Irwin, 1996.
35. Shah S.B., *Illuminating the Possible in the developing World: Guaranteeing the Human Right to Health in India*, in «Vanderbilt Journal of Transnational Law», vol. 32, 1999.
36. Sen A., *Development as freedom,* Oxford, Oxford Unversity Press, 1999.
37. Thiesen J.K., *A Study of the Effects of Structural Adjustment on Education and Health in Africa,* in G.W. Shepherd, K.N.M. Sonko (Eds.) *Economic Justice in Africa. Adjustment and Sustainable Development,* London, Greenwood Press, 1994.

38. Tomasevski K., *Development aid and human rights,* London, Pinter Publishers, 1993.
39. Tomasevski K., *Health Rights,* in A. Eide, C. Krause and A. Rosas (Eds.), *Economic, Social and Cultural Rights. A Textbook,* Dordrecht/Boston/London, Martinus Nijhoff Publishers, 1995.
40. Van Bueren G., *The Minimum Core Obligations of States under Article 10(3) of the International Covenant on Economic, Social and Cultural Rights,* Fons Coomans, *In Search of the Core Content of the Right to Education,* in Audrey Chapman, Sage Russell (Eds.), *Core Obligations: Building a Framework for Economic, Social and Cultural Rights,* Antwerp, Oxford, New York, Intersentia, 2002.
41. Word Bank, *World Development Indicators 2005,* available online at: http://www.worldbank.org/data/wdi2005/wditext/Cover.htm.
42. World Bank, *World Development Report. A Better Investment Climate for Everyone,* World Bank, Oxford University Press, 2004.
43. World Health Organization, *The World Health Report 2004: Changing history,* World Health Organization, Geneva, 2001.
44. World Health Organization, *The World Health Report 2000. Health Systems: Improving Performance,* Geneva, WHO, 2000.