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## **Jocelyn Keith's prescient question about the human right to health and healthcare**

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### **Article**

Keith, J. (1987). The right to health or the right to health care. *Nursing Praxis in New Zealand*, 2(3), 18-24. <https://doi.org/10.36951/NgPxNZ.1987.008>

### **Synopsis**

In January 1987, Jocelyn Keith (now Lady Keith CBE) was a lecturer in the Department of Community Health at the Wellington School of Medicine and presented a paper at the conference of the Australian and New Zealand Association for the Advancement of Science. An introduction to "The right to health or the right to health care", as it was published in the July 1987 issue of *Nursing Praxis*, sets up a complex problem: What constitutes appropriate healthcare to protect the right to health and wellbeing, in the light of Aotearoa New Zealand's obligations as a signatory to international declarations and covenants; and our Government's obligations to honour Te Tiriti? The forum where the paper was first presented determines Keith's lens. She argues, with reference to contemporary cost-benefit studies, that science advances both high-tech procedures (example: heart transplant) and public health programmes (example: Hepatitis B vaccination). Both are developments that respond to "ever-rising expectations of prolonged life and health" (p. 20); and both programmes cost similar amounts. One programme will directly benefit a very small number of people (n=12), while the other programme reaches a large number of newborns (n=20,000) on the basis of preventing future ill health for a relatively small number. Public health science is constantly needing to seek ways of managing



health need. Further, she makes an argument for an evidence-based direction: “The escalating cost of the aggregation of individual decisions within the health system makes it imperative that science address the urgent need for information about the link between health status and health service” (p. 20). Yet the notion of health conjures up visions of high-tech hospitals delivering complex interventions to provide healthcare, often with inadequate attention to primary health care and public health sciences where the focus is on health promotion and illness prevention.

*Standout paragraph* (Keith, 1987, p. 22)

I believe that there are two different approaches to the relationship of the right to health and the right to health care. There is one which maintains that those who provide the interventions can control the outcome, that more health care (as defined by health professionals) will improve health. The other maintains that the control of interventions lies in the hands of those who use or should be able to use the interventions, but assumes that the means by which this choice is made is, or can be, exercised depends on factors over which they have little control.

These factors are the social, political and economic conditions of individuals and populations to which professionals contribute but do not define. These are public policy choices.

### The article in context

Jocelyn Keith argued for a framework to enact the internationally agreed vision of the right to health and wellbeing with the pragmatic delivery of healthcare that honours Te Tiriti. There are several developments to add to Keith’s 1987 outline of the history of human rights in relation to health, including the United Nations (UN) [Convention on the Rights of Persons with Disabilities](#) in 2006 and the [UN Declaration of the Rights of Indigenous Peoples](#) in 2007. The World Health Organization’s (WHO) [17 Sustainable Development Goals](#) (2015) describe that ending poverty and other deprivations must go hand-in-hand with strategies that improve health and education, reduce inequality, and spur economic growth – all while tackling climate change and working to preserve our oceans and forests. An example of the need to reconcile commitment to internationally agreed aspirations with pressing concerns particular to Aotearoa is the [State of the World’s Nursing](#) report (WHO, 2020). The Report



recognises the central role of nurses in achieving universal health coverage and Goal 3 - good health and wellbeing - yet is all but silent on the promotion of an Indigenous workforce (Chalmers, 2020).

We are familiar with the WHO's founding principle that defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2021, para 1). But there's a question implied in the title of Keith's paper: Is it "the right to health" or "the right to health care"? The commonly used term *the right to health* includes the right to healthcare, and the right to the underlying preconditions for health, including access to safe drinking water and adequate sanitation, healthy houses and environments, safe workplaces, and health-related information. Even so, the right to health does not guarantee an individual's optimal health (Hunt, 2016; Toebes, 1999). Keith argues that "the right to health care" must be understood within the bounds of what signatory nations can resource and choose to prioritise.

We are also familiar with the WHO principle that the right to health applies to all, equally and without discrimination, as "one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (WHO, 2021, para 2). But these distinctions account for the relative social advantages or disadvantages which determine the health gap between those with better or poorer outcomes (Marmot, 2017). The right to health, therefore, includes the broader socio-economic determinants of health.

In the decades since *Nursing Praxis* published an analysis of racism in health service structures (Bickley, 1987) there has been no shortage of evidence and argument about inequality in Aotearoa New Zealand. Evidence of the statistical trends in Māori health over the years 1990–2015 (Ministry of Health, 2019), was prepared specifically for the Waitangi Tribunal's **Health Services and Outcomes Inquiry** (2019). The Tribunal found that the primary health care sector had failed to achieve Māori health equity, and as such, Te Tiriti had been breached. The need to recognise racism's negative impacts on health and wellbeing (Harris et al, 2018) was rendered vividly apparent with the COVID-19 pandemic, shedding a stark light nationally and internationally on the lack of preparedness to protect population health (Sekalala et al, 2020), emphasising the necessity of working *with* communities.

Keith's article anticipated subsequent political efforts to contain health expenditure, drive systems efficiency, and promote a fairer and just system of improving health outcomes. Yet health inequities have persisted. The first major review of the health and disability sector (**Health and Disability Systems**



Review, 2020) in over 20 years has resulted in a white paper signalling major reforms to “ensure every New Zealander can access the right care at the right time” (Health & Disability Review Transition Unit, 2021, p. 1). Like Keith, the Review identified that service users and communities need to be enabled and empowered to engage in a real partnership in their health, including in commissioning health services for their localities.

Currently, the “overly complex and fragmented [system]” (Health & Disability Review Transition Unit, 2021, p. 1) with 20 district health boards (DHBs) and 30 primary health organisations (PHOs) results in a “postcode lottery” (p. 5) of healthcare. Instead, the reforms will replace the DHBs with a single organisation, Health NZ, to plan and commission services for the whole population, in partnership with a Māori Health Authority, and with a central Public Health Agency. General practice services will no longer be funded through a PHO, allowing locality networks of communities and health workers to plan and commission services in partnership with local iwi and Māori. The intention is to refocus population health as foundational for community wellbeing, shifting the balance away from the treatment of illness towards promotive and preventive services. We can perhaps be cautiously optimistic that the new infrastructure enables dialogue that hears the voices of diverse communities and is facilitated to make decisions to improve equitable access and health outcomes for all in Aotearoa.

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