

Editorial

‘The right to health’: a viewpoint

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Terms such as ‘right to work’ or ‘right to health care’ have at least two meanings. The first is that there should be no discrimination – that is, that no one should be excluded *a priori* from consideration for a job or from receiving health care from services established for the purpose. According to that interpretation of rights, people of all races, of all religions, regardless of gender, age or social class should be given the right to apply for a job, to a fair assessment of their competence for it and to employment if they satisfy the relevant technical requirements. In many countries there are legal prescriptions aiming to ensure that this principle is applied. In others, the attention of human rights advocates is focused on removing discrimination and realising human rights in this way – and it is to be hoped that their efforts will be successful.

The second interpretation of ‘rights’ receives less attention. It does not stop at ensuring that there is no discrimination on any grounds but insists on the creation of conditions for the *realisation* of rights. If there are no jobs it is irrelevant whether there is a law guaranteeing equal access to them. Where there are no health services there is little point on insisting that all must have an equal chance to get them. The realisation of human rights in this sense depends on the creation of jobs and the establishment of health services that will be sufficiently well equipped to provide care. They should be created with the understanding that there will be no discrimination in access to them.

To make it possible to satisfy human rights in relation to health care governments will have to review their investment in health. At present developing countries (where the needs are greatest) invest a lower percentage of their gross domestic product (GDP) in health than do the industrialised countries – Pakistan and Nigeria, for example, spend about 2% of their GDP on health, while the Netherlands spends 8% and the USA 12% of GDP on health care. These differences do not bring out the stark reality of everyday life in many developing countries without the expression of the difference in dollars and cents: in Nigeria \$53 is available for health care (per year and

per inhabitant) and in Pakistan the figure is similar – \$48 per inhabitant per year. Thus, even if the developing countries and the developed world were to spend a similar percentage of their GDPs on health, the developing countries would still have no resources to build health care: in absolute numbers the USA spends more than one hundred times more on health care than Nigeria (\$6097 vs \$53 per inhabitant per year).

The development of mental health services is a low priority in most developing countries – so these services receive a much smaller portion of the health care allotment than their counterparts in developed countries. For a while governments justified this situation by referring to the myth of the happy savage – the wrong belief that in the developing countries mental disorders are rarer than in the developed countries. Meanwhile, studies of excellent quality have demonstrated that the prevalence of mental disorders in the developing world is higher than that in the developed countries, a difference mainly due to preventable mental and neurological disorders resulting from causes such as poor perinatal care, early food deprivation, difficult (or lack of) access to health care and ignorance. The fact that the myth of lower prevalence of mental health problems was shown to be wrong has not changed the situation very much, perhaps because of the training and wrong information that the decision makers of today received in their youth. The stigma of mental disorders significantly contributes to this discrimination against mental health services: but it is important to remember that even without stigmatisation mental health services would receive far too little support to function well.

It is unlikely that the situation in the developing world will change very rapidly. Great progress has been made in many countries in the developing world, but the lack of resources is so great that it is necessary to expect that it will be at least several decades before a more satisfactory situation is arrived at. South Korea started as a poor developing country a few decades ago but has reached a GDP comparable to or better than some of the European countries. It

now provides 5% of its GDP in support of health care, some \$1135 per capita per year. Mental health services in South Korea are still being improved – but it is obviously easier to think of better use of resources than of better use of practically non-existent resources. There are few countries that match the rate of economic development of South Korea: so, under these circumstances it is clearly necessary to do something to provide at least minimal care to the many millions of people with mental illness and their families living in the developing world.

Mental health care in the countries that spend a lot of money to provide it is, however, also in need of review and improvement. Reports about the quality of care in many developed countries indicate that mentally ill people have been abused, have been provided with inadequate care and have suffered from discriminatory practices in all walks of life. Some of these problems are also present in the developing world countries, but most of the problems of the developed world are of a different nature and need solutions that are different from those in the developing world. There are, however, some areas in which both the developing and developed countries could use similar approaches and improve mental health programmes. One such area is the development of mental health components in general health care. There is no doubt about the fact that a number of mental disorders – though not all – can be competently handled within the framework of primary health care, regardless of the different forms that primary health care takes in different countries.

The fact that general practitioners in the UK, internists in Japan or primary health care workers in Sri Lanka may learn how to recognise and manage mild depression resolves neither the problem of chronic severe mental illness, nor of the exploration and satisfaction of needs of people with intellectual disability. Yet, the management of some of the mental disorders in primary health care is immensely helpful to people suffering from such disorders and their families and does liberate some of the resources of specialised services so that they can be used for the care of people who need them.

The human rights of the mentally ill in both of the interpretations listed above will not have been fully realised by the introduction of mental health components into primary health care. To achieve this will need much more effort – and therefore action to reach that aim should remain strong and parallel to the most laudable efforts to provide good care to people with mental illness in primary and general health care.

FURTHER READING

- Sartorius N. *Fighting for Mental Health*. Cambridge: Cambridge University Press, 2002. (Published in Korean by HAKJISA Publisher.)
- Sartorius N. Psychiatry in developing countries. In: Henn F, Sartorius N, Helmchen H and Lauter H (eds) *Contemporary Psychiatry, Volume 2: psychiatry in special situations*. Berlin: Springer-Verlag, 2001.