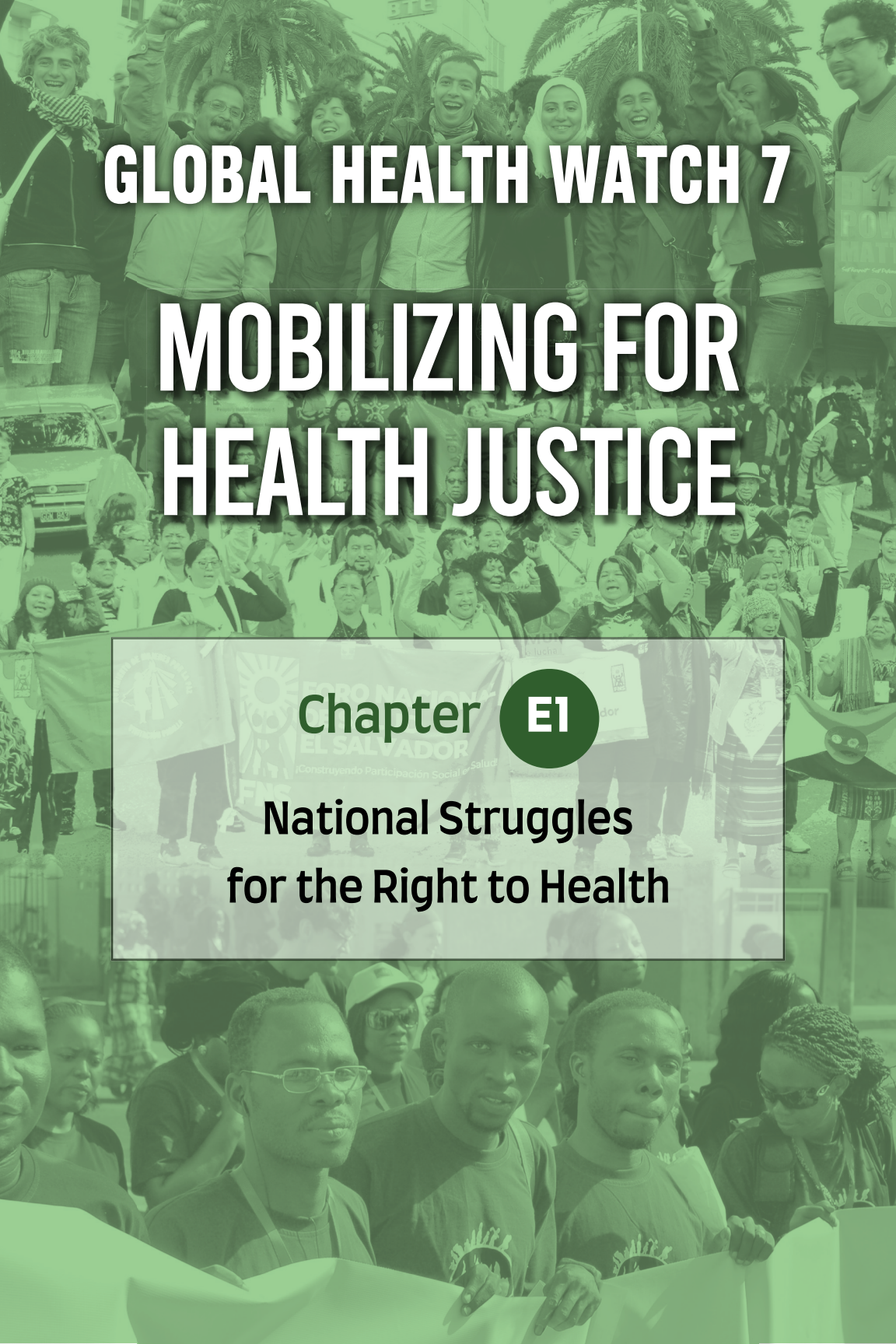

GLOBAL HEALTH WATCH 7

MOBILIZING FOR HEALTH JUSTICE

Chapter E1

National Struggles for the Right to Health

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National Struggles for the Right to Health

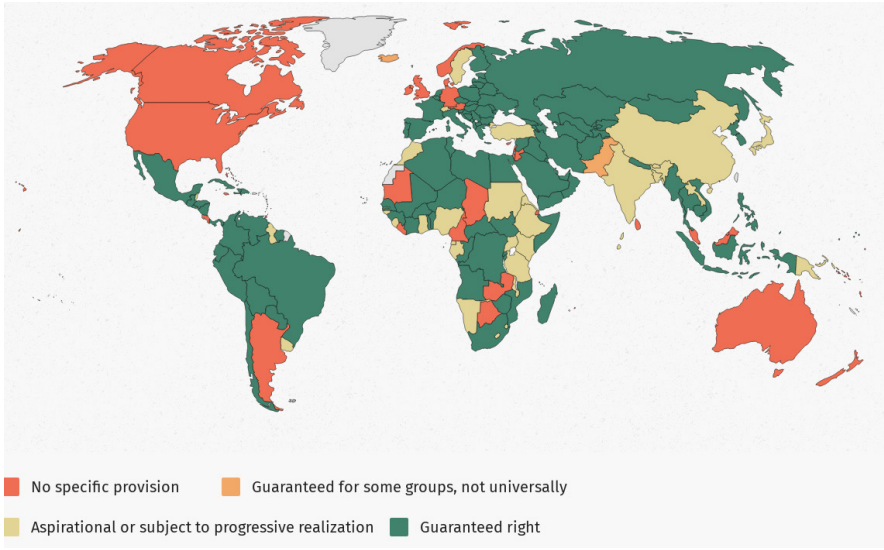
In the wake of World War II, international human rights law started gaining legitimacy as a mechanism for maintaining peace and promoting wellbeing. The broad understanding of health as defined in the Constitution of the World Health Organization (WHO) was reflected in other United Nations (UN) agreements. In 1948, the Universal Declaration of Human Rights stated that: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his 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 lack of livelihood in circumstances beyond his control."[1] Building on this agreement, in 1966 the UN adopted the International Covenant on Economic, Social and Cultural Rights (ICESCR), which guarantees the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health" calling on states to fulfill this right through disease prevention, the reduction of infant mortality and universal access to medical services.[2] In detailing this right, the UN Committee on Economic, Social and Cultural Rights affirmed that "the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment."[3]

At the national level, health rights have become more common over time. Only 29 per cent of the current constitutions adopted before the 1970s explicitly protect health for all citizens, while health is emerging as a priority area among newer constitutions[4] All constitutions adopted in 2000-2017 include the right to health, public health and/or medical care. Significantly, all four of the constitutions newly adopted following the Arab Spring, in Egypt, Tunisia, Libya and Yemen, guarantee in different forms the right to health and / or healthcare.[5]

Overall, 74 per cent of countries worldwide include some form of protection for the right to health in their constitutions (see Figure 1): 58 per cent guarantee health rights, while 16 per cent specify that health rights are aspirational or subject to progressive realization.[6]

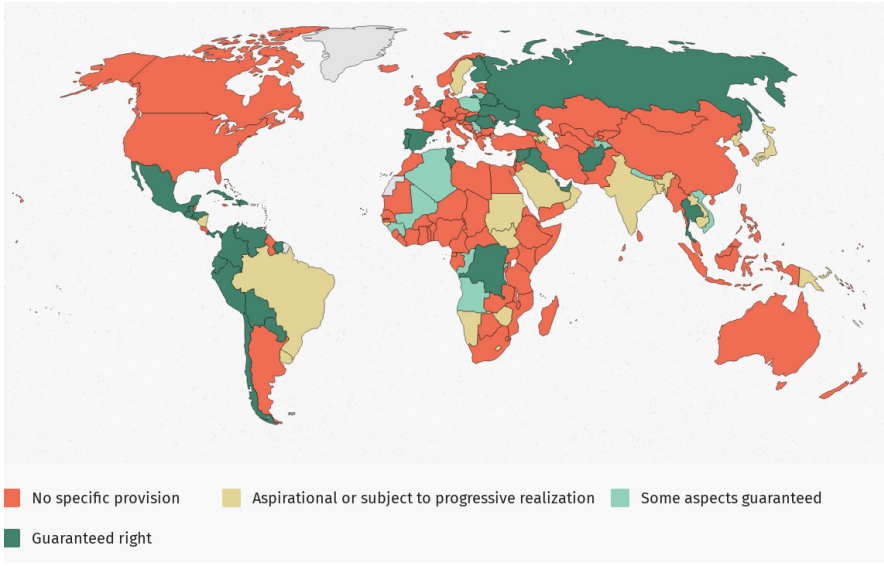
In terms of health rights coverage at the national level, however, the situation varies greatly. In order to address the right to health, constitutions must address both access to health services and the social determinants of health. Protecting and enforcing the right to public health, rather than medical care alone, helps prevent diseases and injuries rather than treating them after they occur. The

Figure 1: Constitutions that explicitly guarantee an approach to the right to health



World Policy Analysis Center. Map reflects constitutions in place as of January 2022.

Figure 2: Constitutions that explicitly guarantee citizens' right to public health



World Policy Analysis Center. Map reflects constitutions in place as of January 2022.

rights to clean water, sanitation and a healthy environment are all aspects of public health. However, relatively few constitutions protect public health for all citizens: 56 per cent address medical care, 47 per cent address the right to health generally, and 36 per cent address public health (see Figure 2). This means that, far more often, countries guarantee a right to medical care than a right to preventive healthcare. Moreover, countries that provide a broad right to health have overwhelmingly interpreted it as a right to medical care.[7]

Among the constitutions guaranteeing the right to public health, the provisions vary widely in scope. Some countries focus narrowly on preventing the spread of disease or providing for specific public health measures, while other constitutions provide for broader public health protections such as organizing a national public health system. Interestingly, although relatively few countries explicitly guarantee the right to public health, nearly half guarantee the right to a healthy environment.

Having the right to health enshrined in the national constitution is not absolutely necessary to fulfill its obligations, as a comprehensive social safety net in legislation and policy may also achieve the goals of fostering healthy environments and ensuring universal quality care. However, evidence suggests that constitutional health rights have the potential to yield additional benefits that strengthen health systems overall[8] including through providing tools for advocacy.

In this chapter we explore through six case studies – from Rajasthan (India), Mexico, Colombia, Kenya, South Africa and Argentina – the interplay between legal provisions in favor of the right to health and the efforts of social movements to promote them, highlighting their shortfalls and proposing how to address them and monitoring the gaps towards their real implementation.

The first three case studies illustrate examples of comprehensive reforms implemented at the state or national level by progressive governments, backed by strong social movements. In different ways, the case studies show that resistance to change may come from within the health sector itself, when corporate interests are threatened. In the case of Colombia, such interests are so powerful that a full reform cannot be enacted. The two case studies from the African continent, from Kenya and South Africa respectively, show attempts to ensure coverage for healthcare services through public insurances. The role of social movements in these countries has been to critically analyze the reforms demonstrating their shortfalls and proposing measures to strengthen their impact on health and equity. Finally, the last case study from Argentina focuses on a reform of mental health care. A progressive legislation focusing on deinstitutionalization, human rights, holistic care and participation was approved as the result of sustained advocacy by human rights organizations, mental health professionals and civil society groups. Despite this success, activists are denouncing an uneven implementation of the provision, revealing significant gaps between legislative

intent and practical outcomes. Overall, the case studies demonstrate how, in many cases, progressive legislations are the result of social struggles, and how sustained mobilization is needed in order to move from a right on paper to a right that is fulfilled for all citizens.

The Right to Health Act in Rajasthan (India): from civil society's triumph to an uncertain future

Rajasthan, the largest state of India, on 21 March 2023 became the first and the only state in the country to legislate the right to health. The "Rajasthan Right to Health Act-2022"[9] (RTH Act) aims to protect and fulfil rights and equity in health, as stated in its preamble. The Act is being hailed as a landmark legislation (as the Indian Constitution does not explicitly provide a fundamental right to health) and the RTH Act is the first ever law in the country that distinctly provides a legal framework for health rights. For a state like Rajasthan with historically weak health indicators, this Act can be hugely transformative.

Provisions of the RTH Act

Contrary to its title, the Act largely focuses on enhancing access to 'health care' rather than addressing the wider determinants of health. Most of the Act caters to strengthening the public health care system and has little on private sector regulation except for the sections on emergency treatment and patients' rights which apply to all health institutions.

One of the most important provisions in the Act is the commitment to provide all health care services, including medicines and diagnostics, completely free from public health establishments to every resident of the state. This provision builds on Rajasthan's earlier schemes such as that of free medicines (2011), free diagnostics (2013) and elimination of all user charges from public health care facilities (2022) with the aim to enhance access to health care and reduce out of pocket expenditure on treatment. The Act also ensures emergency health services in case of accidents and animal bites from private health establishments without any prepayment, committing the government to pay for the services if the patient cannot afford to. This section was one of the Act's major points of contention as we discuss later in this chapter.

The Act outlines various patients' rights and commits to safeguarding the rights of health care providers. It also calls for the establishment of a grievance redressal mechanism and even includes penalties in case of rights violations. For advisory, planning and monitoring purposes and to cater to patients' grievances, the Act mandates the constitution of State and District Health Authorities. The Act also lays down the various obligations of the government such as allocating an adequate health budget.

Civil society struggles and advocacy

The RTH Act is an outcome of years of advocacy by civil society groups in the state led by Jan Swasthya Abhiyan (JSA) Rajasthan (the state chapter of People's

Health Movement India), which called for a legal framework for protecting health rights. The rationale for the demand lay in the fact that Rajasthan, despite some extremely progressive health schemes and relatively decent health infrastructure, continued to struggle with health care delivery gaps alongside high out of pocket payments and below par health outcomes. The JSA's campaign for the Act gained momentum just before the State Legislative Assembly elections of 2018 when it vigorously pushed political parties to commit to the RTH Act in their election manifestos. The party which eventually won the election had done so.

This was followed by JSA's sustained campaigns to push the newly formed government to legislate the Act. JSA provided the first ever blueprint of the Act to the government and maintained continuous public and political pressure for its passage. When the Act faced fierce opposition from the doctors, JSA led counter-campaigns through mass and social media to highlight its importance. They also organized diverse interventions including social media campaigns, memorandum submissions and public meetings to foster public solidarity around the Act.[10]

Agitation by doctors and compromises made into the Act

The Act in its journey faced one of the largest doctor-led protests in the history of the country. Private doctors vehemently opposed the Act, labelling it as "draconian", "anti doctor" and "anti-patient". They perceived that it was a futile law which would sabotage the private health care sector in the state and demanded its withdrawal. The protests were marked by sporadic strikes, huge rallies and massive media campaigns against the Act. The agitation also marked complete shutdown of private health institutions in the state for more than two weeks terribly crippling health care services and causing huge inconvenience to the patients. The protests garnered support from doctors in other states, too. While government doctors refrained from overtly opposing the Act there were instances when a section of them implicitly supported the ongoing protests by private doctors by wearing black ribbons on arms and suspending services briefly. Despite the protesting doctors trying to portray the Act as "anti-patient", people of the state largely appeared to be in favor of the Act as was evident from discussions and citizen led rallies and sit in protests held in different places. While JSA made substantial efforts to translate this support into large scale public mobilization to effectively counter the protests, this remained challenging and met only limited success.

To calm down the agitation, the government was compelled to make some serious compromises in the Bill, such as removing public health experts and local people's representatives from the health authorities and diluting the grievance redressal mechanism. Additionally, as part of negotiations external to the Act, the applicability of the Act on private health institutions was agreed to be limited to medical college hospitals and hospitals with more than 50 beds availing government subsidies, or those under public private partnership.

Current status of the Act, lessons and the way forward

While the Act was passed in March 2023, its implementation remains stalled in the absence of formulation of detailed rules and guidelines. With the change in the state government in late 2023, progress in framing the rules seems to be in a limbo with the new government showing little interest in taking things forward. The future of the Act thus remains uncertain, while civil society groups like JSA continue to advocate for the Act's implementation.

The journey of Rajasthan's RTH Act reaffirms how sustained advocacy rooted in public interest can yield significant results even if it takes a while. It also underscores the significance of mass awareness and people's engagement in a campaign. While it exposes how private interests may obstruct public health goals, it also reassures that if there's a political will any impediments can be overcome.

The future of RTH Act in Rajasthan yet again depends on the efforts by the civil society in pushing for the framing of the rules and their implementation. Hopefully, the Act will overcome the challenges as it did before and will soon see effective implementation. The Act is also envisaged to pave the way for other states to legislate similar laws ensuring health rights across the country.

The right to health during Mexico's Fourth Transformation*

Since 2018, Mexico has been experiencing a significant shift with the arrival of a left-wing government, the result of a social movement that, for over a decade, transformed public outrage into hopeful activism. Under the presidency of Andrés Manuel López Obrador[11] the new government called on its members to commit to dismantling a neoliberal model that, over five decades, had severely impacted fundamental social rights, including the right to health.

Redefining health priorities in a new political scenario

The Fourth Transformation has faced the challenge of redefining health priorities within a fragmented system that could not be fully deconstructed quickly. Given these constraints, the government chose to address two deeply rooted issues as priorities: corruption and the privatization of the healthcare system. In this vein, a constitutional reform was promoted to establish the State's role as the principal guarantor of public health. This led to creating a new institution, the Instituto Mexicano del Seguro Social (IMSS) Bienestar[12] which has centralized healthcare services under the federal government's authority in 23 of the 32 states (the governors of the outstanding states have not joined the federalization), promoting equity in access and quality of health services for the uninsured population.

*Mexico has undergone four major transformations. The first was its Independence from Spain; the second, the Reform War, which separated the clergy from the State; the third, the Mexican Revolution; and, since 2019, we have experienced the Fourth Transformation of public life in the country, peacefully and without violence.

Community engagement for the right to health

During the neoliberal era, so-called "civil society" primarily operated through organizations that obtained tax benefits from donations made by private corporations and agencies like USAID, fostering a sector more aligned with private interests than with advocating for the right to health. In contrast, the Fourth Transformation encouraged the involvement of activists and workers from social movements within the healthcare system, promoting republican austerity* and focusing on collective health and community well-being.

An essential strategy in this context has been to work directly with communities to redefine health as a social right. The COVID-19 pandemic illustrated how health as a human right was sometimes used for selfish purposes, with individual interests often prioritized over the common good. For example, when the first vaccines, such as Pfizer's, became available, it was impossible to immunize the entire population. Thus, vaccines were administered in stages, starting with healthcare workers treating COVID-19 patients. The second phase included national authorities, like the president, teachers, the elderly, and people with chronic illnesses. Subsequent stages prioritized other vulnerable groups. Seven out of ten Mexicans patiently waited for their turn to be vaccinated. Through campaigns and field activities, the government promoted the importance of prioritizing the common good, encouraging the population to protect and promote collective health actively. This shift has reinforced solidarity and a sense of community responsibility around public health.

Specific organizations that previously enjoyed tax benefits expressed criticism of the Fourth Transformation, defending their interests under the guise of being a "social movement." However, this period also revealed the persistence of patriarchal privileges within some organizations, where men continued to intervene in women's spaces, such as midwifery. In response, the government is working to ensure that the right to health is genuinely inclusive, respecting women's knowledge and rights in their practices and traditional knowledge.

Reforms within the healthcare system

Another essential advancement in this transformation has been the creation of the "megafarmacia para el bienestar", a centralized resource guaranteeing free access to prescribed medications in public health institutions. This initiative, supported by revitalizing national laboratories, has been essential for reducing dependency on private pharmaceutical companies and advancing the country toward greater health sovereignty.

*The principle of austerity in contemporary Mexico aims to use the health budget more efficiently. Previously, more than 50 per cent of this budget was allocated to salaries. When President Andrés Manuel López Obrador took office, he reduced his salary and ruled that no public official could earn more than the president. As a result, officials now receive a modest salary, but one that is sufficient to live with dignity. Another measure was to improve the organizational structure by eliminating duplicated areas to optimize resources.

For the second phase of the Fourth Transformation (2024-2030), with Claudia Sheinbaum Pardo as the first woman president, there are plans to formally integrate traditional medicine into the healthcare system across all states, recognizing its cultural value and contributions to comprehensive care. One challenge will be the local restructuring of the health system and the strengthening of comprehensive and integrated primary health care. A current tendency to prioritize curative over preventive services limits the reach of public health policies.

Way forward

Eight out of ten citizens in Mexico support the Fourth Transformation. This broad acceptance is partly explained by the fact that each decision is communicated and explained to the public, and, when necessary, submitted to popular decision through citizen consultation. In this context, the population has understood and accepted this reengineering of the health system. The detractors represent the remaining 20 per cent of the population, with a conservative and largely exclusionary ideology, favoring only allopathic medicine and supporting transnational pharmaceutical companies.

In sum, the health reforms promoted by the Fourth Transformation aim to redefine the right to health in Mexico with an active role for the State as the guarantor of this right. Through actions aimed at combatting corruption and privatization, alongside the federalization of services and incorporating traditional and community practices, Mexico is advancing toward a more equitable and socially responsible healthcare model.

Attempts to institutionalize the right to health in Colombian legislation

The institutionalization of the right to health in Colombian legislation has been one of the components of the political struggle in health that has taken place in this country over the last three decades. The struggle was between the hegemonic sectors that developed health as a private consumer and market good against the counter-hegemonic sectors that understand health as a common good and a fundamental human right.

The right to health or the right to privatize health?

The Colombian Constitution of 1991 did not establish health as a fundamental human right, but rather as a public service run by public and private entities regulated by the State. This constitutional decision laid the groundwork for a process of privatization of the health system, which was implemented with Law 100 of 1993[13], based on the approach of structured pluralism.

This Law established a health insurance system with the participation of insurance companies, mainly of a private nature, which took control of the public resources of the health system. With the subsequent approval of Law 100, a political dispute intensified in Colombia between various political, social, union and academic sectors over the type of orientation of the health system and the recognition of health as a fundamental human right.

This social confrontation, which took many years and multiple exercises of denunciation, collective action and demand from various expressions of the social health movement in Colombia, bore fruit with the issuance in 2015 of Law 1751, known as the Statutory Health Law (LES, for its acronym in Spanish).[14] LES explicitly enshrined health in the constitutional order as a fundamental right and established the basis to guarantee its effective protection. Its implementation, however, has faced challenges due to the structure of the health system model based on insurance through assurance entities and service providers, which generated a mixed, fragmented and inequitable vision of access to care. As part of the political contest, since 2015 the social health movement in Colombia has been demanding that the LES be truly implemented, an issue that has not yet been achieved.

The health system reform: health as a public good

The current administration of President Gustavo Petro (2022-2026) proposed a comprehensive reform of the health system, which has sought to align the legislation and the service delivery model with the principles of the LES with a focus on guaranteeing the right to health as a public good rather than as a business. The objectives of the health system reform proposed by the Petro government include the need for the State to take a more active role in the management and provision of health services, eliminating the financial intermediation of insurers, with the State contracting directly with the service provider network, thereby strengthening the public care network to guarantee equitable coverage throughout the national territory. This coverage would be organized under the PHC approach with services that are not limited to curative care but that include health promotion and disease prevention and prediction, aligning with a comprehensive public health approach.

This proposed reform of the health system has reflected many of the historical aspirations of social and health professional associations and trade union movements in the health sector. This is why it has received the support of these sectors with public statements, the development of forums and public debates, presence in the Congress of the Republic and with mobilizations, among other strategies, although the reform has not had broad popular support due to confusing reporting by the mass media to create opposition to it. In particular, health workers have supported the reform initiative but have stated that the proposals for the formalization of the workforce in this sector must be adjusted to overcome the precariousness of work established by the neoliberal labor and social security policies in health at the beginning of the 1990s.

Lessons learned and future prospects

This experience of promoting a reform of the health system leaves us with the lessons that the design of a good technical proposal by the government is not enough, even when it reflects the historical aspirations in this field of the social

and labor sectors. A broad social and popular mobilization is required to achieve a reform of this type, as it is necessary to confront and prevent the political and economic sectors that historically control the health sector from continuing to do so, and to apply social pressure on the Congress of the Republic to make legislative decisions that effectively guarantee the right to health.

The content of the reform must seek to truly overcome the vested interests of the medical-industrial-pharmaceutical and insurance complex and effectively manage to go in a different direction to that imposed by the hegemonic biomedical model, because otherwise it means reforming the system so that everything remains the same.

It is certainly not possible to comply with the LES without reforming the health system, which removes health from the commercial logic and ensures equitable and fair access to health based not on people's ability to pay, but on their social and health needs. At the moment, the hegemonic sectors have not allowed the approval the health system reform in the Congress, and the political battle to institutionalize and operationalize the right to health in Colombian legislation is still in force.

The right to health in Kenya: legal framework and recent developments

The right to health is enshrined as a fundamental human right in the Constitution of Kenya, 2010, which provides a comprehensive legal framework for health services based on human rights.[15] Article 43(1)(a) ensures every person the right to the highest attainable standard of health, including sexual and reproductive health rights. Articles 43(2) and 43(3) guarantee emergency medical treatment and social security for those unable to support themselves. For children and marginalized groups, the constitution mandates affirmative action to ensure reasonable access to health services and other basic amenities. Nevertheless, healthcare workers continue to violate this provision especially as gay men stay silent for fear of harassment or stigma. In most cases the Kenyan LGBTQIA+ do not reveal their sexual identity while accessing health care, unlike refugees in the refugee camps and those living in urban areas where their status is known. This exposes them to risks of attack and discrimination while accessing healthcare services, such as being denied treatment.

Universal health coverage and national hospital insurance fund reforms

Kenya has prioritized universal health coverage (UHC) through the National Hospital Insurance Fund (NHIF), which had previously provided medical cover to government staff and salaried employees of private firms in the formal sector.[16] In 2015 NHIF introduced new premium contributions, expanded benefits and reformed provider payment methods. These reforms have faced challenges. Premiums were unaffordable for the majority of Kenyans working in the informal sector. Further, the changes were inadequately communicated, creating barriers

for equitable access. Additionally, health services were distributed unevenly, favoring urban areas and private providers, which undermined access to services for rural communities and the urban poor. The new provider payment rates were often delayed, which impacted service quality and financial accountability. Finally, social accountability was consistently undermined, with NHIF governance manipulated for political spoils.

In 2018, the Kenyan government piloted a new model for UHC in four of the country's 47 counties. By mid-2019, PHM Kenya and others across civil society were already identifying major gaps in both the design and implementation of this flawed UHC model. In early 2020, all four governors in the four pilot counties declared the UHC pilot a failure and suspended further implementation. The onset of the COVID-19 pandemic in March 2020 further exposed the gaps in the national and county health systems.

Social Health Insurance Fund Act and new health laws

Health remained a key social and political priority through the 2022 national elections, which led to a change in government. During the political campaigns, health was a priority for both major political formations and was part of their manifestos, so to some extend health played a role even if the election was won based primarily on better economic promises.

In 2023, the new Kenyan government promised free healthcare and later announced the dissolution of NHIF, replacing it with the Social Health Authority (SHA) under the Social Health Insurance Fund Act 2023 (SHIF Act).[17] Despite aims to broaden coverage and reduce out-of-pocket expenses, the SHIF Act introduced several contentious elements:

- The benefits package does not match with premium contributions to market rates, particularly affecting low-income households.
- Contributions, set at 2.75 per cent of gross salary, are higher than under NHIF, potentially creating financial strain, especially for those also paying for private insurance.
- The contribution framework for informal workers relies on a means-testing instrument that lacks validation, risking inequity and discrimination against these workers.

These issues were addressed in a court ruling that deemed the SHIF Act and accompanying laws unconstitutional due to their design flaws, lack of required public notice and participation, and inequitable impact on certain populations.

Challenges and struggles

PHM Kenya and other civil society organizations mobilized and together evaluated the proposed Act and its accompanying new laws (bills), analyzed gaps in the bills and presented a petition to the parliament for consideration, identifying these concerns:

- There is no clear definition of emergency care.
- No representation of civil society seats on the SHIF board.
- The benefits package under SHIF are much lower than the market rate.
- The lower benefits package for households with lower tariffs would be discriminating.
- The structure of benefits and contribution promotes classism, thus giving better quality care to those with higher incomes.
- Identification of the destitute through use of means testing tool is likely to attract costly administrative implications.
- Emergency treatment and ambulance costs are not covered.
- It eliminated the provision for return of unused funds to treasury (consolidated fund) at the end of each financial year.

The parliament ignored the proposals by civil society and hurriedly passed the bills into law on 27 September 2023, comprising the Primary Health Care Bill, the Digital Health Bill, the Facility Improvement Bill and the Social Health Insurance Bill.

There has been a serious gap in the service delivery by the health service providers during the system changeover from NHIF to SHIF that left patients without cover as they were neither in SHIF nor in NHIF. Patients seeking dialysis and oncology care were at risk of not being able to access services affordably and on time.

Figure 3: PHM Kenya comrades in solidarity with Kenya Medical practitioners and dentists Board championing for better healthcare system and advocating for the right to access proper healthcare

PHM Kenya

Public participation and multi-stakeholder engagement

PHM Kenya submitted a memorandum to Parliament with recommended changes to the health laws. Meanwhile, the government initiated a national rollout of the new SHA program from 1 October 2024 following a stay order on the high court ruling, although public concerns about the reforms remain high, and many analyses of its design identify serious flaws in terms of equity and universality of coverage, affordability, accountability and even gaps in benefits as compared to the flawed NHIF that is being replaced.

PHM Kenya continues to highlight service delivery strengths and lapses in SHIF through workshops and campaigns targeting health activists, service consumers and grassroots service providers, in trying to demystify SHA including constitutional health rights in Kenya.

The National Health Insurance Act in South Africa

In May 2024 South Africa passed the National Health Insurance (NHI) Act into law.[18] The Act establishes a National Health Insurance Fund that will be financed through a mandatory prepayment system. This fund aims to move South Africa towards a "single payer" system that provides a comprehensive package of health care services free at the point of care. Both public and private providers can apply to provide services and receive payments from the fund, and private medical aid schemes will eventually only be able to finance services that are not covered by the NHI Fund (though these have not yet been specified). The fund will only be used to purchase services for citizens, permanent residents and inmates in detention facilities. Adult asylum seekers and undocumented foreign nationals are only eligible to receive coverage for notifiable conditions and emergency medical services. All children, regardless of nationality, will be eligible for the full package of benefits purchased by the NHI Fund.

Reaction by Social Movements

People's Health Movement South Africa (PHM SA) took part in a series of actions and engagements aimed at advancing a "People's NHI" that points out the dangers of corporate capture under the current version of the NHI Scheme.[19] These dangers stem from the fact that there is no clear legal framework for: (1) ensuring community participation in decision-making about resource allocations, (2) prioritizing allocation of NHI funds to facilitate improvements in and expansion of the public health system, (3) operationalizing an intersectoral and preventative approach to health care, and (4) ensuring that everyone in South Africa has access to healthcare, including non-citizens.

From the time the first draft of the NHI Bill was published PHM SA organized several interventions aimed at ensuring it creates more than just a public financing model, and to prevent public resources being used to subsidize and strengthen the private sector. This included co-hosting a strategy seminar in 2010 with key civil society organizations with the objective of influencing the NHI Green Paper (released in 2011).[20]

Figure 4: Activist mobilizing for National Health Insurance

Rosetta Msimango/Spotlight www.SpotlightNSP.co.za

Subsequently, PHM SA drafted 5 different submissions on various iterations of the Bill,[21] including a special "Young People's Position Paper" on the 2015 NHI White Paper. The content of these submissions was generated collectively by the PHM SA steering committee and in consultation with community health workers (CHWs), community health forums, and clinic committees that PHM SA works with. An archive of the numerous NHI materials PHM SA has developed can be found online,[22] including more recent analyses of the NHI.[23,24,25]

NHI shortcomings and way forward

These contributions, in collaboration with those of other civil society organizations such as SECTION27, helped to increase oversight and accountability provisions in the NHI Act. The NHI Act, however, remains problematic in a number of ways: the legislation enacts a health financing mechanism but does little to:

- regulate private actors in the health market as recommended by the Competition Commission in its Health Market Inquiry;[26]
- specify legally binding obligations to ensure the strengthening of the public health sector;
- give formal recognition to CHWs as public sector employees;
- include mechanisms for communities to hold to account private sector actors that provide services under the NHI;
- give all non-citizens full access to the rights and privileges granted to citizens and permanent residents;
- address the climate impact of the health system; and
- move beyond being illness- and hospital centric.

PHM, alongside other civil society organizations in South Africa, continue to organize to address these shortcomings in the legislation, and to defend the principle of a primary care oriented and solidarity-based health system from co-optation by private healthcare providers and their allies.

The implementation of National Mental Health Law in Argentina

The enactment of Argentina's National Mental Health Law (Law 26.657) in 2010 marked a milestone in the country's legislative framework for health.[27] This law was celebrated as a progressive step toward institutionalizing the right to health, specifically mental health, within a human rights framework. It emphasized deinstitutionalization, community-based care and the protection of human rights for individuals with mental health conditions. Despite its groundbreaking approach, the law's implementation has faced numerous challenges revealing the complexities of translating legislative gains into tangible improvements for health equity.

Background: the right to health in Argentina

Argentina's health system is characterized by a mix of public, private and social security sectors, with disparities in access and quality of care. Historically, mental health was a neglected area, with policies heavily reliant on institutionalization in psychiatric hospitals. Patients were often subjected to poor living conditions and human rights abuses. The National Mental Health Law aimed to address these systemic failures by aligning Argentina's mental health policies with international human rights standards, including the United Nations Convention on the Rights of Persons with Disabilities.

Key provisions of Law 26.657

The law was groundbreaking in several ways:

1. Deinstitutionalization: it mandated a shift from hospital-based care to community-based services, aiming to integrate individuals with mental health conditions into society.
2. Human rights focus: it prohibited involuntary treatment and the prolonged institutionalization of individuals, unless under strict judicial review.
3. Holistic care: the law advocated for an interdisciplinary approach to mental health, integrating social, psychological and medical perspectives.
4. Participation: it emphasized the involvement of individuals with lived experiences and their families in the design and implementation of mental health policies.

The role of social movements

The passage of Law 26.657 was the result of sustained advocacy by human rights organizations, mental health professionals and civil society groups. These actors highlighted the abuses within the psychiatric system and framed mental health as a fundamental human right. The movement also drew strength from broader

campaigns for social justice and equity in Argentina, leveraging the country's robust tradition of activism.

Challenges in implementation

Despite its promise, the implementation of the law has been uneven, revealing significant gaps between legislative intent and practical outcomes:

1. Insufficient resources: the transition from institutional to community-based care requires substantial investment in infrastructure, workforce training and social support systems. However, funding for mental health has remained limited, with less than 2 per cent of the national health budget allocated to the sector.
2. Resistance from institutions: psychiatric hospitals, which have historically dominated mental health care in Argentina, resisted the changes mandated by the law. This resistance has slowed the process of deinstitutionalization.
3. Lack of training and awareness: many healthcare professionals lack the training to adopt the interdisciplinary and human rights-oriented approach required by the law. Public awareness of the rights enshrined in the legislation is also low, limiting its impact.
4. Judicial bottlenecks: while the law requires judicial oversight for involuntary treatment, delays and inconsistencies in the judicial process have often undermined the protection of patients' rights.

More than a decade after its passage, the National Mental Health Law's transformative potential remains only partially realized. Deinstitutionalization is far from complete, and community-based services remain underdeveloped. Moreover, stigma and discrimination against individuals with mental health conditions persist, undermining the law's goal of social inclusion.

Lessons learned and strategies

Several lessons emerge from Argentina's experience with Law 26.657:

1. Sustained advocacy is crucial: the role of social movements in pushing for the law's enactment demonstrates the importance of grassroots mobilization. However, these movements must remain active to ensure effective implementation.
2. Institutional resistance requires addressing power dynamics: the reluctance of traditional psychiatric institutions to adopt the new framework highlights the need for political will and leadership to overcome entrenched interests.
3. Investment in community-based care: adequate funding and resource allocation are critical to realizing the law's vision of community-based mental health services.

4. Public engagement: raising awareness about mental health rights among the general population can create pressure for better implementation and hold institutions accountable.

Argentina's National Mental Health Law offers valuable insights into the complexities of institutionalizing the right to health through national legislation. While it represents a significant legislative achievement, its challenges underscore the need for continued activism, adequate funding and systemic reform to translate legal frameworks into real-world equity and justice. The case of Law 26.657 is a poignant reminder that legislative victories, though essential, are only the beginning of the struggle for health as a human right.

Conclusion

Over the past few decades, a growing number of constitutions and legislations across the world have started to recognize and enforce the right to health, shaping citizens' access to public health and medical services.[28] Despite the challenges explored in this chapter, this has both yielded positive impacts for individuals and populations, and allowed for structural improvements to national health systems.

As the case studies in this chapter illustrate, the growing recognition of the right to health is the result of decades of social struggles in which social movements, including health movements, have played a central role. The challenge for such movements is to sustain the advocacy effort which often requires skills and capacities at both the technical and analytical level, and at the level of popular mobilization. As the cases of Colombia and Argentina show very well, without the capacity to alter the power dynamics and challenge the interests of those who benefit from the status quo, any reform project becomes disempowered. Moreover, activist pressure must be sustained over time to move from a good legislation proposal, to its approval without compromises that weaken it, to its real implementation. Despite the described limitations, all case studies show that the engagement of social movements and civil society activism are essential drivers of any reform that may enhance the recognition and the enforcement of the right to health.

Reference List

1 United Nations General Assembly. Universal Declaration of Human Rights. United Nation General Assembly; 1948 Dec. Report No.: A/RES/217(III). Available from: https://bit.ly/4kvCis0

2 United Nations General Assembly. International Covenant on Economic, Social and Cultural Rights. 14531 Dec 16, 1966. Available from: https://bit.ly/3SM5uz9

3 United Nations Economic and Social Council. General Comment No. 14: The Right to the Highest Attainable Standard of Health. UN Committee on Economic, Social and Cultural Rights; 2000 Aug. Report No.: E/C.12/2000/4. Available from: https://bit.ly/4je5hja

4 Heymann J, Sprague A, Raub A. Advancing Equality: How Constitutional Rights Can Make a Difference Worldwide. California: University of California Press; 2020. Available from https://doi.org/10.1525/luminos.81

5 Saleh SS, Alameddine MS, Natafgi NM, Mataria A, Sabri B, Nasher J, et al. The path towards universal health coverage in the Arab uprising countries Tunisia, Egypt, Libya, and Yemen. The Lancet. 2014 Jan;383(9914):368–81. Available from: https://bit.ly/43byxCq

6 World Policy Analysis Center. Constitutional Approaches to the Right to Health. WORLD Policy Analysis Center. 2020. Available from: https://bit.ly/3SNozRz

7 Heymann J, Sprague A, Raub A. Advancing Equality: How Constitutional Rights Can Make a Difference Worldwide. California: University of California Press; 2020. Available from: https://bit.ly/4dy5ZGP

8 Heymann J, Sprague A, Raub A. Advancing Equality: How Constitutional Rights Can Make a Difference Worldwide. California: University of California Press; 2020. Available from: https://bit.ly/4dy5ZGP

9 PRS Legislative Research. The Rajasthan Right to Health Bill, 2022. Rajasthan; 2022. Available from: https://bit.ly/4jq8ufK

10 Newsclick. JSA urges Raj Govt to make clarifications in health bill to ensure effective implementation. Newsclick. 2023 Apr 3; Available from: https://bit.ly/3FudxNY

11 López Obrador AM. A mitad del camino. México: Editorial Planeta Mexicana; 2021. 327 p.

12 Secretaría de Salud. IMSS Bienestar. 2023; Available from: https://imssbienestar.gob.mx/

13 El Congreso de la Republica de Colombia. Ley 100 de 1993. 41.148 Diciembre, 1993. Available from: https://bit.ly/3SNovkN

14 El Congreso de la Republica de Colombia. Ley 1751 de 2015. 49427 Feb 16, 2015. Available from: https://bit.ly/4du8wBP

15 El Congreso de la Republica de Colombia. Ley 1751 de 2015. 49427 Feb 16, 2015. Available from: http://bit.ly/4du8wBP

16 National Health Insurance Fund (Kenya). Bima Bora Afya Bora! Available from: https://bit.ly/45cLSfh

17 Government of Kenya. The Social Health Insurance (General) Regulations. Available from: https://bit.ly/3H5v1kt

18 Department of Health Republic of South Africa. National Health Insurance Backgrounder. Available from: https://bit.ly/4kdD1OY

19 People's Health Movement South Africa. The People's NHI Campaign. People's Health Movement South Africa. Available from: https://bit.ly/43GCkYr

20 Department of Health Republic of South Africa. National Health Insurance in South Africa Policy Paper. 2011 Aug. Available from: https://bit.ly/3Ft5aCl

21 Health Justice Initiative. National Health Insurance Library: User guide. Available from: https://bit.ly/4dxyvbx

22 People's Health Movement South Africa. The People's NHI Campaign. People's Health Movement South Africa. Available from: https://bit.ly/43GCkYr

23 Bust L, van Duuren J, Reynolds L, London L, De Keukelaere A. Critical Health Perspectives #1: National Health Insurance in South Africa – A Brief History and Critical Analysis. People's Health Movement South Africa. 2022. Available from: https://bit.ly/4dtXBYB

24 Bust L, Reynolds L, Paremoer L, De Keukelaere A. Critical Health Perspectives #2: Financing of the South African National Health Insurance and involvement of the private sector. People's Health Movement South Africa. 2022. Available from: https://bit.ly/4dDRVvl

25 Twala B. Critical Health Perspectives #3: How strengthening governance can improve NHI. People's Health Movement South Africa. 2022. Available from: https://bit.ly/3SOg3li

26 Competition Commission South Africa. Health Market Inquiry: Final findings and recommendations report. Competition Commission South Africa; 2019 Sep. Available from: https://bit.ly/4kooZd0

27 Barcala A, Faraone S. Advancements in mental health reform in Argentina: towards comprehensive and human rights-respecting care. The Lancet Regional Health – Americas. 2023 Oct;26:100615. Available from: https://bit.ly/43AVBJ0

28 Heymann J, Sprague A, Raub A. Advancing Equality: How Constitutional Rights Can Make a Difference Worldwide. California: University of California Press; 2020. Available from: https://bit.ly/4dy5ZGP