The Demands of the Human Right to Health

Jonathan Wolff

Department of Philosophy

University College London

j.wolff@ucl.ac.uk

Abstract: The human right to health has been established in international law since 1976. However philosophers have often regarded human rights doctrine as a marginal contribution to political philosophy, or have attempted to distinguish 'human rights proper' from 'aspirations', with the human right to health often considered as falling into the latter category. Here the human right to health is defended as an attractive approach to global health, and responses are offered to a series of criticisms concerning its demandingness.

The Universal Declaration of Human Rights of 1948 sets out a bold account of what is owed to all human beings as a matter of right. Yet it has taken some decades for political philosophers to appreciate that the Declaration may have some relevance to their own work. Within a certain fairly broad mainstream, the Declaration was, for many years, simply ignored.[1]

This is not, of course, because of antipathy to the notion of a right as such. When Rawls's *A Theory of Justice* was first issued in paperback in the UK, the publishers chose to put the following on the back cover:

> 'In a just society', writes John Rawls, 'the rights secured by justice are not subject to political bargaining or to the calculus of social interests'.[2]

Very soon, though, this looked like a better description of Robert Nozick's libertarianism, based, essentially, on the right to self-ownership, or even the very different work of Ronald Dworkin who set out an account of 'rights as trumps'. Yet in neither of these works was a positive connection attempted with the Universal Declaration. Alasdair MacIntrye summed up the attitude of many philosophers to the Universal Declaration:

> The best reason for asserting so bluntly that there are no [natural or human] rights is precisely the same type as the best reason we possess for asserting there are no witches [or] unicorns: every attempt to give good reasons for

[1] For example, the topic of human rights is barely, if at all, touched on in Rawls, (1971), Nozick (1974), Dworkin (1977) and Walzer (1983).

[2] This is from the OUP 1973 paperback version, and the text is taken from Section 1, p. 4.

> believing that there *are* such rights has failed…. In the United Nations declaration of 1948 what has since become the normal U.N. practice of not giving good reasons for any assertions whatsoever is followed with great rigour. (MacIntryre 1981, p. 67)

Somewhat later, a more concessive path developed, taking the basic idea of human rights as sound, but the Universal Declaration as flawed. On one account the flaws are very deep, for they mix up 'human rights proper' as Rawls calls them, with statements of some other sort, such as liberal aspirations, or rights that need a certain type of institutional framework and therefore cannot be universal (Rawls 1999, footnote 23, p. 80). A famous version of this mixed attitude to the Universal Declaration is Maurice Cranston's *What Are Human Rights?*, in which human rights to life, liberty are treated with great respect, and the human right to property receiving more muted approval, but economic and social human rights heavily criticised, to the point of ridicule (Cranston 1973).

What explains political philosophers' failure to embrace the UDHR, either at all or in its entirety? Sometimes it is said that it is a shoddily conceived or hastily drafted collection of ideas, lacking coherence or justification. It has been treated as an embarrassing perversion of political philosophy containing 'howlers' such as the human right to holidays with pay. Cranston argues that the inclusion of such rights is both philosophically mistaken – confusing different 'logical categories' of rights – and politically damaging. Such confusion brings discredit to the general idea of human rights, so he argues, and therefore undermines what he regards as the genuine human rights. Cranston also argues that while civil and political rights are easy to make part of a formal legal system – 'a large part of the legislation needed has to do no more than restrain the government's executive arm' (1973, p. 66) – securing economic and social rights extension provision presupposes a higher level of wealth than is available in much of the world. This type of argument, though, has been thoroughly discredited by Henry Shue, who points out that civil and political rights also require the state to protect each citizen from each other, which requires the extremely costly and elaborate apparatus of the police and the criminal and civil justice system (Shue, 1996).

The type of antipathy to human rights expressed by MacIntrye, appears to be less prevalent now. Many will agree with Charles Beitz's remark that human rights exist as an attempt to correct a defect in the way political history has led to the development of the world as a 'society of states' each with a concentration of power over its citizens. Human rights doctrine attempts to provide a much-needed counter-weight, where a citizen can appeal to the world community in disputes with his or her government (Beitz 2009, pp.128-130). But this alone doesn't settle the question of whether economic and social rights, and especially, the human right to health, should be regarded as 'human rights proper'.

It may be helpful to look at things a different way. Instead of nitpicking at the Universal Declaration, and worrying about different 'logical categories' of rights (as

if that notion is itself clear in any case) let us consider the extraordinary fact that in 1948, after 2,500 years of dispute on principles of justice and the basis of legitimate political order, people from different philosophical, cultural, ideological, religious and national traditions, after great effort and intense debate, arrived at a consensus statement of what was owed to each individual, as a matter of right. Much as some might have wished the drafters had used the language of social justice, or something else, or phrased the rights a different way, or put them in a different order, they did not. But what the United Nations then did, and continued to do, was follow up with further covenants and declarations, and set about attempting to give effect to human rights in international law. Given the institutionalisation, influence and prestige of the Universal Declaration, there are reasons to ask consider whether it is, after all, good enough as a statement of what people of world are owed, rather than proposing, in effect, that we should rip it up and start again. Even if we think it not ideal, or not as good as some other possible approach, The Universal Declaration has a sixty year head start, and the crisis that brought it into existence – the Nazi atrocities – was, we should hope, a unique opportunity in which nations could be persuaded that something like a Universal Declaration was needed.

On inspection, the Universal Declaration does indeed set out a highly attractive vision. Consider, for example Article 25 (1), which, according to its critics, is not generally thought to be one of the 'human rights proper', as it concerns the distribution of economic and social goods:

> 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. (United Nations 1948)

Admittedly there are some oddities in the formulation: the reference to family seems unnecessary and may reflect an assumption that the scope of 'everyone' is adults only, and possibly male adults only, although such a gender restriction would conflict with other provisions of the Declaration. But putting this aside, if we really could ensure all the peoples of the world had access to what Article 25 (1) demands, then would there be further work for political philosophy? Well, it could be said, an adequate standard of living is all very well, but surely people need a range of civil and political rights, and to be engaged in work in some form in order to have a meaningful life. But of course the drafters agreed with this, which is why Articles 3-18 and 23 and 24 respectively are present too. And of course there is much that would need clarification and development in detail, although it could be asked whether philosophers, rather than lawyers and policy makers, are the right people to do this.

One way for political philosophers to respond to the Universal Declaration, therefore, would simply be to accept it, and say that, for the moment at least, a great deal of political philosophy is now settled.[3] Just as debate on many issues in the

[3] I should not be taken as saying that there would not be any work remaining for political philosophers. Clarification of concepts and fashioning of ideals remain

United States starts by taking the Constitution as its starting point – a type of normative fact – the Universal Declaration could, and arguably should, play the same role in political philosophy. On such a view there is much to be said about details of application, but all fundamental doctrine is in place.[4]

Difficulties with Human Rights Doctrine

The Declaration, however, was just that, a declaration. It was not drafted to be legally binding and it was not until 1976 that the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Right formally became part of international law. In the case of some of the articles, the Covenant version of the right is much more expansive. Let us take the central case for this paper – the human right to health:

> 12 (1) The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. (United Nations 1966)

This, clearly, goes far beyond a 'standard of living adequate for health', and such a formulation has led to a train of powerful objections, all broadly connected with the idea that the human right to health is too demanding, or at least makes the wrong kind of demands. Criticism of this nature re-opens the philosophical discussion that many had hoped would be settled by the generation of the conventions of international law. Here I want to consider five types of criticism. The first is that the human right to health is too vague. The second is that it does not allocate duties correctly. The third is that it is unnecessary. The fourth is that it distorts efficient spending. And the fifth is that it is damaging. Some of these criticisms, or versions of them, apply to all economic and social rights, others apply only to the human right to health. But it will be the human right to health – to the highest attainable standard of health – we consider here.

It the Human Right to Health Too Vague?

The notion of the right to the 'highest attainable standard of health' is problematic, and, as critics point out, is stated in ambiguous terms. What does 'attainable' mean?

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important tasks, and I do not want to be understood as somehow casting doubt on the legitimacy of such reflection. But insofar as political philosophy is to be applied to policy, especially in international contexts, much of the groundwork has already been done.

[4] Those sympathetic to MacIntrye may find this philosophically outrageous. Is nothing to be said about the foundations of human rights? Indeed I think there is much to be said on this topic: see Wolff 2011.

'Attainable with application of all know techniques and technologies' or 'attainable with current local resources'? The real difficulty is not so much the ambiguity as the unattractiveness of both options. If we are to offer everyone the right to the highest attainable standard of health we seem to face the 'bottomless pit' objection. For each of us there are ways in which our health could be improved, at least marginally, through the provision of medical services. Do we really have a right that our governments provide us with this? There would be no money for anything else. So, it seems, we must interpret 'attainable' as 'attainable' given current resources. But for poor countries this is disappointly unambitious (O'Neill 2005, p. 429).

The term 'highest attainable' may be unfortunate. But it can be interpreted as meaning something like 'highest reasonably attainable'. The question is then how to construe it. First, we need to recall that the right to health is not the right to health care, even though in practice this is often where the focus will lie. There are many determinants of health, with health care being only one, and perhaps not the most important when compared to hygiene, sanitation, nutrition and adequate housing. (This indeed is implicitly recognised in the Universal Declaration.) But equally it cannot be the right to be healthy, for contingencies of genetics and biology make it impossible to ensure that everyone remains healthy. What, then, is it?

Following an idea from Henry Shue, I want to suggest that the essential element in the human right to health is the right to be protected against 'standard threats' to health (Shue, 1996, p. 17, 29-34). Shue points out that essentially the same issue arises for all rights. Even the right to freedom from assault cannot be completely guaranteed. What the ordinary citizen can have, though, is protection from standard threats, which will take the form of a well-enforced legal code offering various entitlements and protections, such as making certain types of interventions by others criminal or civil offence.

What is a standard threat to health? To be a threat it has to be relatively serious. The borderlines are fuzzy but not impossibly so. Death is certainly a threat in the relevant sense, as are conditions that lead to severe suffering, such as broken bones. Equally, medical problems leading to social ostracism, such as some forms of disfigurement or other stigmatised conditions, can be understood as posing a significant threat to health. It is more difficult to say what it means for a threat to be 'standard'. There will certainly be a historical contingency depending on the state of medical knowledge and technology. But the important question is whether there is variability between countries. Of course, in one sense there is. No one in Iceland need worry about the threat of malaria, unlike sub-Saharan Africa. But more important is whether a condition experienced in two countries can be treated as a standard threat in one, but not the other. Take HIV/AIDS. It is routinely treated now in the developed world, and those unable to find treatment may justly complain that they are not being protected from a standard serious threat. But in Swaziland, say ten years ago, almost no one received treatment. Should we say that, though very common, it was not a standard threat in the required sense?

This seems to me the wrong conclusion. A condition seems to be a standard threat to health where, first it is serious enough to count as a threat, and second a solution could reasonably be expected to be in reach, either because treatment could be made available on a routine basis, or because the condition is widespread and urgent and there is every reason to think that the normal processes of scientific research would lead to a solution. Of course issues of cost of treatment will be relevant, and we will return to this, but the response to our first criticism is that there is no need to be distracted by the notion of the 'highest attainable' standard of health. The important point is that a right to health is, or is at least centrally, the right to be protected from standard threats to health, where protection includes not just prevention but access to curative measures too.

Is the Human Right to Health Incoherent in Its Allocation of Duties?

Onora O'Neill is, in one way, an unlikely critic of human rights given her longstanding interest and involvement in issues of global poverty and justice. But, as in much of her work, she emphasises the point that the notion of a right, strictly speaking, is empty unless it is possible to identify the obligation holder in respect of that right. She then makes a sharp distinction between 'liberty rights' which generate universal 'first order' duties, and right to goods and services in respect of which the first order duty holders are much harder to identify. While she acknowledges Shue's point that even in the case of 'liberty' rights, the state has extensive duties to protect one person from others, nevertheless she is able to make her distinction at the level of 'first order duties'. And indeed O'Neill produces a penetrating analysis of the difficulty of assigning duties in respect of social and economic rights and the complexities of implementation in practice (O'Neill 2005).

Many of O'Neill's detailed criticisms about the difficulties in allocation of duties are well made. It is not always clear where the duty should fall. Many countries do not have the resources to provide access to expensive medications that are needed to prolong life and improve health, for example for people living with HIV, or suffering from drug resistant TB. Governments in poor countries simply cannot provide for the health of all their citizens, at least not without significant assistance. But what, though, does this show? It would, in the first instance, lead one to think that the work of setting out the correlate duties is not finished yet: this is a point that the United Nations would acknowledge itself, as it continues to produce a stream of further guidance in the form of General Comments, such as the famous General Comment 14 in relation to the human right to health. The international community, including wealthy countries, and drug companies, will find themselves with human rights duties to act in order to fuflill the right to health of all. There is much work to be done both in clarifying the allocation of the duties, and bringing international actors to accept and act upon them. This, indeed, is work O'Neill has attempted to think through for herself, by, for example, contrasting the difficulties posed by 'rogue states' and 'weak states', which certainly present different types of challenges to the international community. What she seems to have left unexplained is why her account is presented as a critique of human rights doctrine, rather than as part of a helpful application and development of the duties that correlate with human rights.

Furthermore, there is a sense in which the human rights regime is a victim of its own success. The partial implementation of human rights doctrines in international law has allowed its difficulties to be seen fairly clearly. No other doctrine in political philosophy has received such attention and open scrutiny. All theories of justice implicitly allocate duties, but the discussion of such duties has tended to be extremely sketchy: consider the question of who has the duty to implement Rawls's two principles of justice, or, even more acutely, luck egalitarianism. In practice this has not mattered as so few theories have ever been put to the test. If we insist that justification in political philosophy is comparative, which is to say that pointing to a problem with a theory is only decisive if that theory can replaced with a better one, then human rights doctrine looks pretty secure, at least in respect of the issue of the allocation of duties. It is hard to see what warrant there is for the thought that setting out the duties correlating to a doctrine of human rights is harder than for any other substantive political philosophical position.

Is the Human Right to Health Unnecessary?

When we look at facts of early death and illness around the world the picture is quite appalling. In some countries in the world it is still the case that more than one in four children die before the age of five. Maternal mortality remains shockingly high. Here are some widely cited figures, from a joint statement by the WHO, UNFPA, UNICEF, and the World Bank in 2008:

> Every minute a woman dies in pregnancy or childbirth, over 500,000 every year. And every year over one million newborns die within their first 24 hours of life for lack of quality care. Maternal mortality is the largest health inequity in the world; 99 per cent of maternal deaths occur in developing countries—half of them in Africa. A woman in Niger faces a 1 in 7 chance during her lifetime of dying of pregnancy–related causes, while a woman in Sweden has 1 chance in 17,400. (WHO et al, 2008)

Number five of the Millennium Development Goals set out by the UN in 2000 was 'Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio.' This required year-on-year improvement of 5.5 per cent between 2000 and 2015. In 2009 the UN put out a statement on maternal mortality and human rights acknowledging the scale of the problem and the very unimpressive pace of improvement to date: 1 per cent per year (United Nations 2009).

It is easy to come to believe that for women and children to be placed in a situation where they face such threats is a violation of their human rights. Yet we are not short of arguments that provide reasons for those in wealthy countries to act. From

Peter Singer onwards a powerful line of argument suggests that we have extensive moral duties to help those in a desperate position wherever they are. Singer, in fact, says very little about how he understands such moral arguments, presumably wishing to appeal to as broad a spectrum as theorist as possible (Singer 1972). Given widely expressed worries about the foundation of human rights, and worries about the expansive nature of economic and social rights – rights to goods and services – why complicate matters by appealing to a more controversial argument based on human rights, when simpler humanitarian arguments are available?

The problem, unfortunately, is that humanitarian arguments are limited in their implications. Humanitarian concern addresses the urgent needs of people often in emergency situations. Typically such people are starving, or refugees from war, or victims of a natural disaster. Humanitarianism relieves them of their most urgent immediate needs. But it does nothing to change the underlying structure. Rich donors remain rich. Those giving to charity sometimes remark they do not even notice any effect their charitable donations have on their life style. The poor remain poor, though, for the moment, not in desperate need. Humanitarian aid is essentially conservative; it preserves existing power structures. To give aid is to be strong, while to need it is to be weak. In its Development Plan, Namibia has set out the ambition that by 2030 it will dispense aid to others countries rather than receive it (National Planning Board of Namibia 2004). By contrast recognising someone's rights is, as Jack Donnelly put it, to put them in control (Donnelly 1999, p. 61). It is to accept another person's legitimate claims to power. Rights claims are not restricted to needs, but also extend to liberties and opportunities. And once people have power they may use it in ways that surprise you. Indeed, ways that disturb you. Not all surprises are pleasant, as former colonial powers found out when post-colonial states could pick their leaders for themselves. But that is what it is to accept that others have rights. Humanitarianism is, therefore, attractive to those who are in power and like to keep things that way. If we believe that the world order should change in such a way that developing countries must be able to take charge of their own fates, then there is good reason to recognize human rights. (This may seem a strange claim when many of the most successful developing countries may not have recognized the human rights of their own citizens. But the focus here is not domestic policy but international relations.)

Is The Human Right to Health Too Expensive?

In a short commentary in the *Financial Times* that provoked quite a reaction in the human rights to health movement, development economist William Easterly argued against the human right to health as a basis for health care (Easterly 2009). We should recall, of course, that the human right to health concerns not only health care, but also the right the determinants of health: those things that keep you well, such as food, housing and sanitation, and not just medical care. However, we can keep the focus on health care for the purposes of the current discussion.

Easterly makes two main charges. For clarity we will consider them in two

separate sections. In this section we will look at his claim that the human right to health diverts resources to those who shout the loudest and have the best connections, so increases inequality and distorts cost-effective planning. His idea is that those who pursue human rights claims are likely to be wealthy, or at least in some sense privileged and well-connected. If they win their cases then their victory will have to be funded. It would not have been worth fighting if the treatment demanded was not expensive. Therefore significant amounts of money will have to be found, and the only place where this money can come from is elsewhere in the health budget. Consequently, allowing people to go to court to pursue their human rights to health will undercut rational planning, and is likely to lead to less efficient use of health resources, in terms of not generating the greatest health benefits.

I believe that though there may be some truth in this picture in respect to wealthy and middle income countries, it has less application in the developing world, where notions of cost-effectiveness do not apply in the same way. To explain, consider how decisions are made with respect to access to treatments with the British National Health Service. At present, when a drug is found to be safe enough and effective enough to be placed on the market a ruling is needed about whether it should be made available to doctors on the NHS to prescribe to their patients. This decision is currently taken by NICE – The National Institute of Health and Clinical Excellence – and drugs are approved if they provide sufficient additional health benefit given their cost. Some drugs are ruled out as not cost-effective, in that they do not provide enough health gain – measured in quality adjusted life years (QALYS) – for the money they will cost. Given that there is a relatively fixed budget, this seems an appropriate, if not entirely uncontroversial, way of allocating resources, even if there is a good deal of room for dispute about the details. Inevitably, however, cost-effectiveness analysis will lead to some cases where people are denied treatments that would prolong their lives, if the cost is very high for the benefits it brings.

From time to time NICE appraisals are challenged in the courts. There are also cases where an individual issues an action against the government for access to a particular treatment. One UK case was *Rogers versus Swindon NHS Primary Care Trust* where a women sued for access to the breast cancer drug Herceptin, considering such denial to be a violation of her human rights (to life, rather than health), among other objections. In the event the court felt able to decide in her favour, and order a review of the decision to deny her and others in her position treatment, without investigating human rights issues. Note, though, that their decision was not to order treatment, but a review of the decision procedure (MedLaw, n.d.).

An important case from outside the UK is that of Sobramooney in South Africa, where the plaintiff – a man with serious kidney failure, among many other problems – argued that his right to life and right to health, both guaranteed by the then new South African constitution, gave him a right to dialysis at public expense. Unfortunately, the state hospitals did not have a sufficient number of machines to meet the demand, and so had set up a system of rules to allocate access to dialysis machines. On this basis Sobramooney had been denied access. Consequently he took his case to the constitutional court. While very sympathetic to his situation the court accepted that hard decisions had to be made, and that the place to make them was not the court but the hospital. So as long as a fair procedure was in place, and had been followed, the action could not be allowed, and his rights to health and life had not been violated

Here the court followed an important UK precedent:

> I have no doubt that in a perfect world any treatment which a patient, or a patient's family, sought would be provided if doctors were willing to give it, no matter how much it cost, particularly when a life was potentially at stake. It would however, in my view, be shutting one's eyes to the real world if the court were to proceed on the basis that we do live in such a world. It is common knowledge that health authorities of all kinds are constantly pressed to make ends meet. They cannot pay their nurses as much as they would like; they cannot provide all the treatments they would like; they cannot purchase all the extremely expensive medical equipment they would like; they cannot carry out all the research they would like; they cannot build all the hospitals and specialist units they would like. Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgment which the court can make. (Constitutional Court of South Africa 1995, citing Sir Thomas Bingham MR in a passage cited by Combrinck J from the judgment in *R v Cambridge Health Authority, ex parte B.*)

In the circumstances, to provide treatment for Soobramoney would have meant taking it from another, who had been declared a higher priority by the allocation decision (essentially it would have been someone declared a better prospect for eventual transplant). So a correct decision has been made, it seems. Yet one may have a creeping suspicion that the situation is best described as one involving a tragic conflict of rights, rather than a fully 'clean' decision.

However, other jurisdictions have acted in a different way. In Brazil very many – perhaps tens of thousands – of cases for access to treatment, in accordance with the right to health or right to life, have come to court and many are successful. And just as Easterly suggests, it is not the poorest who gain access this way. It is not the richest either – they can pay for their own medication – but the articulate or well-connected middle classes (Ferraz 2009). So there is something to Easterly's case, and if the health budget is fixed, and money is diverted away from other areas, then, it is quite possible that less cost-effective measures will be taking resources away from more cost-effective ones, to the overall detriment of total population health. But even if cost-effectiveness is not threatened, the point remains that some people will be better able to work the system than others.

When we turn to poorer countries the position is much more complex. The human right to health movement has coalesced around the problem of HIV/AIDS, and in particular access to anti-retroviral treatments, which in the great majority of cases can extend healthy life very considerably if administered correctly. Let us to return to the world of the National Institute of Health and Clinical Excellence, and consider how cost-effectiveness analysis might apply to the supply of ARV.

Although there are exceptions and qualifications the basic idea in the UK is that NICE will authorize drugs for prescription by the NHS if they meet a threshold of around £20,000 per QALY and will refuse to do so if they cost more than £30,000. In between those figures NICE uses its own judgement in a manner that is not at the moment entirely transparent, but is likely to take such things as the severity of the

condition into account. Different forms of ARV cost different amounts, but one figure I have seen given for the UK is £16,000 per year. At that cost, the treatment could be argued to meet even the lower threshold for people who would be expected to die without treatment, in that it allows people living with HIV something like a normal life. The improvement in health experience is dramatic and the therapy cost-effective.

Now let us take a country such as Mozambique. Until the last few years the cost of ARV drugs on the world market were, at least initially, of the same order as the UK price. But if Mozambique had an equivalent to NICE its threshold for approval could not be £20,000 per QALY. Mozambique's GDP per capita, according to the World Health Organization, is $770 and spending on health per person $50 (WHO n.d.1). The equivalent figures for the UK are $36,240, and $3,399 (WHO n.d. 2). The UK can afford a QALY threshold of £20,000 or above, because we are a wealthy country, and relatively few of us are seriously ill. It is easy to see why supplying ARVs in the developing world has often been said to be not cost-effective.

The simple argument, then, would seem to be that Mozambique should not supply ARV drugs as to do so would not be cost-effective. The opportunity cost of attempting to do so, as economists never tire of reminding us, would be to strip out just about all other public spending and so ruin other aspects of health policy, as well as education, transport and other sectors. But not treating people living with HIV would have devastating effects, denuding the country of its workers, rendering the country even poorer with even less to spend on health, leading to a fatal downward spiral and threatening even the continued existence of the country. Cost-effectiveness analysis in resource poor settings with a health emergency is itself a problem, not a solution. Just as we saw that humanitarian aid is conservative, cost-effectiveness analysis seems fatalistic.

This is not to say that issues of cost-effectiveness are irrelevant in the developing world. If there is a cheap way and an expensive way of accomplishing the same goal, and no side effects, cost effectiveness analysis has a useful function. Furthermore, if a treatment can be said to be cost-effective relative to other ways of spending the same amount of money then that can be a powerful form of advocacy. And indeed when the WHO declares a treatment regimen cost-effective, as it has done for some treatments for multi-drug resistant TB (WHO 2010), then a powerful message is sent to potential donors. Passing a cost-effectiveness test is very powerful.

The question is, what follows from failing such a test? For the developing world the main weakness with cost-effective analysis as just described is that it takes drug prices for granted. Providing particular therapies often fails to be cost effective because drug prices are so high. Why are they so high? Prices reflect the extensive research and development costs not just for the drug in question but the many unsuccessful research efforts where funding must be recouped if the company is to remain in business. But it does not follow that world prices must all be the same. It is not a natural fact the drug prices are high. If, in the developing world, they are high that is because of the decisions of drug company executives, as well as those who set out the international patent regime. Accordingly treatments can become cost-effective if drug prices change. This can be done in two ways, either simply by companies lowering prices or by finding ways round patent regimes to encourage the production of generics. Both have been attempted, with some considerable success. But this was

done not by accepting the consequences of cost-benefit analysis, but by showing how it was possible to treat people in the developing world with advanced medications, and then using treatment success as a way of pressurizing decision makers to change drug prices and patent claims to allow cheap drugs to be supplied more broadly in the developing world.[5]

Furthermore, it is simply not the case that the developing world is in a position analogous to the UK or even Brazil (GDP $10,080, spending on health $943) (WHO n.d. 4) with regard to health resource allocation decision making. The UK has a relatively fixed budget for health spending, and this budget remains fixed however the money is spent. In a country such as Mozambique, with few natural resources, and a very small tax base, a large proportion of health spending is externally funded by donors. And a good deal of this money is given for specific purposes, as a result of advocacy by pressure groups and NGOs. If money provided by a donor is tied to a specific purpose, then it is simply not available for other purposes. What may, then, in the abstract appear not to be cost-effective, may turn out, in a sense, to be very cost-effective in that any attempt to spend the money in a different way will be likely to lead to a loss of the funds.

The technique, pioneered by Paul Farmer and others, of, in effect, shaming drug companies, donors and governments to find ways of supplying and funding essential medicines, has proven very important. Where cost has been an obstacle to meeting the human right to health, ingenuity has been used to drive costs down and to increase funds, rather than to allow vital projects to be derailed by considerations of cost-effectiveness and opportunity cost. However, this strategy has its limits. Sometimes costs are high not because of patents but because of, for example, training and staffing costs. Take the example of maternal mortality, mentioned above. Why are women dying in childbirth? Because of obstructed labour, hemorrhage and sepsis. Broadly, it has been argued, women the world over suffer the same problems in delivery (Yamin and Maine 1999). In some countries the facilities are there to turn emergencies into routine medical procedures with a very high success rate. In other countries emergency services and blood banks are not there, but even if they were women living in rural locations could not reach them in time anyway. Certainly some low cost initiatives can help – for example giving midwives mobile phones to call the emergency ambulance – but maternal mortality will remain high until there is wide development of operating theatres and blood banks, and forms of transport to take women there if need be. But no one has provided a model of how this can be done cheaply.

Should we abandon campaigns to lower maternal mortality on the grounds that the steps needed to do so will never be cost-effective? This, it appears, is where the economic analysis will leave us. Rather, we should see the fact that it is not cost-effective to improve maternal mortality in the developing world as a human rights

[5] See, for example, Médecins sans Frontières South Africa et al (2003). Thomas Pogge has argued that price differentiation in different countries would lead to a black market (Pogge 2005, p. 187). In practice, however, it seems possible to control supply to prevent serious problems. See, for example, the work of the WHO Green Light Committee (WHO n.d. 4).

tragedy or scandal. Ideally we would want to see increases in the wealth of the countries affected so that improving maternal care does become cost-effective. But in the meantime, the most promising strategy, surely is a human rights approach which puts duties on the international community to assist those countries that cannot, on their own, meet their 'core human right to health obligations'.

In conclusion, while the notion of cost-effectiveness is vital for rational distribution of extensive, but nevertheless limited, health resources in the wealthy world, it is hugely damaging if used as a test for access in health care policy in the poorest countries of the world. This, of course, is not to say that there is no room for cost-effectiveness analysis in, say, choice of techniques, but rather it cannot be used as the last word on whether to pursue treatment programmes for mass, life-threatening conditions. The resources should fit round the treatment programme, rather than treatment programme fit into existing resources.

Is the Human Right to Health Damaging?

In his high-profile critique of the human right to health Easterly also makes a second criticism: that the human right to health encourages concentration on vertical health programmes, which are problematic from the point of view of health systems. What he means is that a funder – whether the Gates Foundation, Wellcome Trust, private charity or government programme – pursuing a human rights agenda may well spend a great deal of resources on dealing with one disease. Think of PEPFAR – the President's Emergency Plan For AIDS Relief, or the Global Fund for AIDS, TB and Malaria, or the Gates' initiatives to eradicate polio and malaria.

Now a major strand in these programmes is often laboratory research. But they also support a good deal of work in the field, setting up dedicated clinics, treatment centres, home visits and so on. The problem, both with research and treatment, is that they take people away from whatever else it was they were doing. If, for example, Gates decides to put a huge amount of money into researching ways of eradicating malaria, but, as some suspect, this is a vainglorious project with no chance of success, he is wasting the time of some of the world's best scientists, who will no longer be researching other conditions where they might have had better chance of success. Similarly, in developing countries where funding for HIV programmes has increased, it is been documented that the number of attended births and childhood vaccinations has declined (Haacker 2009). The reason for this, of course, is that the new programmes need trained staff, and in hard-pressed health systems this means taking staff away from other roles. The movement of health workers in such 'internal brain drains' is widely observed.

Easterly is not the first to draw this problem to public attention. Indeed human rights to health activists have also done so, and many donors have come to understand the problems: indeed, they are devastated to learn that their money, effort and good

intentions are having significant negative consequences. But there are two points to make in response to Easterly. First, there are now various attempts to try to resolve or avoid this problem, for example by training more staff, and second, it is unclear why Easterly thought it was a special problem for the human right to health, which is increasingly being addressed to 'health system strengthening' or 'horizontal' programmes, rather than vertical programmes. There are difficulties of course. It is much easier to campaign and raise funds to deal with a specific issue, such as AIDS or malaria, rather than for the general idea of improving health systems, but still suchwork is taking place. And AIDS and malaria do need to be addressed, so there is a genuine dilemma here. In conclusion, vertical programmes do some damage to health systems, but it is wrong to think that they are somehow intrinsically or exclusively linked to the human right to health.

Conclusion

I began by suggesting that political philosophy has, at least until recently, paid too little attention to the Universal Declaration of Human Rights, which could provide a sound basis for an attractively just society, and has the benefit of being a consensus statement by people from very different philosophical, religious and cultural traditions, as well as sixty years of institution building. However, the Covenant on Economic, Social and Cultural Rights goes further in specifying these rights, and, in the case of the human right to health does so in a way that is initially problematic, seeking the 'highest attainable' standard of health for all.

I considered a number of objections. The first is that the right is too vague. I suggested, following Henry Shue's usage, the human right to health should be understood as providing protection against a series of 'standard threats' to health, which is to say that where it is possible to prevent or treat illness in a routine manner, then each of us has a right to expect this from our governments, with international assistance if that is necessary. Second, that the Declaration and Covenant do not adequately allocate duties. I accepted this, but suggested that it is a gap that needs to be filled, and is being filled, rather than a devastating objection. Third, that a doctrine of human rights is unnecessary. In response I pointed to the conservatism of humanitarian responses in terms of redistribution of power. Fourth that it distorts health spending priorities. Here I argued for the inappropriateness of using cost-effectiveness analysis as a basis for making final rulings on health policy in the developing world. Finally I considered the criticism that human rights to health advocacy leads to vertical programmes that damage health systems. Here I acknowledged that such damage is being done, but that it is wrong to think that this is a problem especially associated with the human right to health. In my view taking the human right to health seriously offers the best practical and philosophical prospect we have for making significant inroads into the global burden of disease.[6]

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