The Right to Health, International Law, and Economic Justice

N Swazo

Citation

N Swazo. *The Right to Health, International Law, and Economic Justice*. The Internet Journal of Law, Healthcare and Ethics. 2006 Volume 5 Number 1.

Abstract

Background: Proponents of free market conservatism object to the idea of a right to health per se, distinguished from a right to health care. They insist on the importance of economic growth and private affluence, efficiency in production and consumption in the health sector, and eschew governmental regulation.

Discussion: The free market conservative approach to health care ignores some fundamentals of human rights discourse, the basic features of international law, and the demands for economic justice in the health sector. This is particularly problematic in light of the economic disparities between industrialized and developing countries, as well as the immense global burden of disease in the latter.

Summary:
1. The right to health is a fundamental human right, having the status of a non-derogable right.
2. The declaratory tradition of international law, with its attention to progressive achievements, does not eliminate State obligations to recognize, protect, and fulfill the right to health.
3. A just economy recognizes the obligation of States to regulate distribution in the health sector.
4. Globalization elicits attention to the task of articulating a global public health ethics.

Health and human rights are complementary approaches to the advancement of human well being. --Dr. Gro Harlem Brundtland, Director-General, World Health Organization

The naïve idealist who thinks he knows truth—without accounting for competing claims of the self-interests of others—is a danger. We need the insight of both children to forge truly moral social policies. --Joel Rosenthal, President, Carnegie Council on Ethics in International Affairs

BACKGROUND

It is well known among those familiar with the declaratory tradition in modern international law that various quasi-legal instruments secure to persons a right to health. I speak here of a declaratory tradition in the sense used by Dorothy Jones[1]: "At the core of the declaratory tradition in modern international law is a set of nine fundamental principles that constitute a summary of state reflection upon proper action in the international sphere."[2] "Equal rights" and "respect for human rights and fundamental freedoms" are among these basic principles. In short, the various participants in international relations, via governmental and non-governmental organizations, have themselves convened under numerous auspices to commit themselves severally and jointly to a set of principles and practices that are to guide or govern their conduct in the interest of a more humane and just world order. What count as "human rights" or "fundamental freedoms" remains subject to debate within human rights discourse generally as ostensibly universalist aspirations are checked by particularist, perspectivist, and relativist critiques of the universalist thesis.

Notwithstanding the scope of the debate, explicit commitments to human rights are manifest in various "declarations," including well-known documents such as the Universal Declaration on Human Rights (UDHR) of 1948, the two International Covenants (1966) that specify political and civil rights (ICCPR) as well as economic, social, and cultural rights (ICESCR), the UN Convention on the Elimination of All Forms of Discrimination against Women (1979), the UN Convention on the Rights of the Child (1989), the UNESCO Declaration on the Responsibilities of

the Present Generations Towards Future Generations (1997), and the more recent UNESCO Universal Declaration on Bioethics and Human Rights of 2005. In each of these we have an expressed "agreement on common values" proper to international society, these various agreements undertaken to advance the welfare of persons and peoples whatever their socioeconomic status and stage of political and economic development, as well as to contribute to international peace and the security of nation-states.

Some may argue that such declarations have neither moral nor legal authority. That is, insofar as they are deficient vis-à-vis pertinent sanctions for lack of compliance, they remain wholly voluntary and rather ineffective instruments, such that declared rights remain merely putative. Such declared rights, then, are held to be categorically distinct from stipulated provisions of bilateral or multilateral treaty that, by contrast, do hold signatory parties mutually accountable for compliance through institutionalized means of juridical review and disposition of grievances.

As stated at the outset, among declared rights in various formal documents is a right to health. The Constitution of the World Health Organization asserts that, "Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity," and affirms further that, "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (italics added). This statement is in agreement with Article 12.1 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR), which asserts, "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." Addressing comment on this article in May 2000, the UN Committee on Economic, Social and Cultural Rights judges the right to health as a "fundamental human right indispensable for the exercise of other human rights," and asserts further that this right is "conducive to living a life in dignity."[3] Viewed from the perspective of international health, it then becomes meaningful to speak of "the global architecture for health governance"[4] even as it is meaningful to link this right to programs of action for sustainable development—a concept that envisions meeting "the needs of the present without compromising the ability of future generations to meet their own needs."[5] As was made clear at the World Summit on Sustainable Development held in Johannesburg South Africa in 2002, "Health is far more central to poverty reduction than previously thought;" the fact is "sustainable development cannot be achieved where there is a high prevalence of debilitating illnesses, and the health of the population cannot be maintained without a healthy environment."[5] Indeed, "Addressing the underlying determinants of health through intersectoral efforts is key to ensuring sustained health improvements and ecologically sustainable developments."[5] Even so, as Lawrence Gostin and Jonathan Mann note, "Even so fundamental a human rights concept as the right to health has not been operationally defined, and no organized body of jurisprudence exists to describe the parameters of that right."[6]

But, given the above-noted categorical distinction, a declared right to health such as that set forth by WHO or affirmed in the ICESCR remains, at best, merely putative. It has been argued, furthermore, that there are ample pragmatic reasons to deny or avoid all claims to such a right insofar as such a right is "a [questionable] positive claim upon the resources of others." Yet, at least at the level of moral intuition or prima facie response, a position that denies or avoids all claims to such as right seems morally repugnant, thus presumptively indefensible. One is inclined to think that such a position is surely to be found indefensible when subjected to careful examination. Here I propose to engage the question whether one reasons correctly in construing a right to health as merely putative. In other words, I propose to determine with some degree of cogency whether indeed this is a fallacious interpretation and judgment about the declared right to health. By implication, then, if my critical evaluation is successful, my extended argument has the additional consequence of vindicating the position of those who not only claim such a right as an entitlement of persons but who also act to secure its status as a universal human right.

My point of departure and contestation is a position advanced by Timothy Goodman in a recent issue of the Journal of Medicine and Philosophy, whose basic argument I shall summarize in brief in Section I. [7] In Section II, I identify Goodman's position as one representative of the political philosophy known as "free market conservatism," the point being that Goodman's position entails a particular philosophical commitment that is but one among a number of theoretical options in (modern) political philosophy. In Section III, I shall evaluate the line of argument adduced by Goodman in the theoretical context of free market conservatism and show why that line of argument is

untenable. My approach in this section includes: (1) clarifying the character of international human rights law, specifically the declaratory tradition in international law; (2) examining the meaning of non-derogable rights so as to consider whether the right to health may be so construed; (3) taking note of the recent report of the UN Special Rapporteur on international institutional policy and practices relative to the right to health; and (4) showing why an alternative economic philosophy diminishes the force of Goodman's free market conservatism as applied to the health sector.

DISCUSSION

SECTION I: THE ARGUMENT VIS-À-VIS MARKET CONSEQUENCES

Goodman asks two questions at the outset of his challenge: "What is the basis for viewing health as an entitlement, rather than as a good provided through the market like any other? If health is in fact a right, who is responsible for providing and paying for it?" He opines that a "careful consideration of these questions suggests that access to health care would likely become less secure, not more, if government supplanted markets as the driving force behind the production and diffusion of health-related goods and services."[8]

Clearly, Goodman's questions already present the issue within a framework of political economy that privileges free market (thus private) enterprise over governmental (thus public) regulation that acts for the common interest and domestic welfare where the market fails to achieve "the public good" as measured by the aggregate delivery of products and services. Because free market enterprise is to be privileged, government action in this case is construed negatively as a "supplantive" act. Further, Goodman considers several political difficulties associated with the idea of a right to health, noting the empirical facts that (a) "Disease, physical deterioration, and death remain intrinsic to the human condition," and (b) "any particular individual's health status is at least partially a function of his or her voluntary behavioral and lifestyle decisions." Inasmuch as one (other than "the most extreme libertarians") cannot reasonably expect government to criminalize individual behavior that is not conducive to personal health, so Goodman argues, it is unreasonable to expect governments "guarantee good health to its citizens." Goodman then posits that assertions of a right to health actually intend a "right to health care, redeemable by government," presumably such that this right entails "access to some (rarely specified) level of health care" and "the constraints, trade-offs, and scarcities inherent in market-based economies do not apply"[8]—though we can be clear Goodman thinks they should apply.

Goodman construes declarations of a right to health as part of a "post-modern" view of rights, which, on his interpretation, means that proponents reject "the view that human beings are naturally situated within relationships of dependence, and that rights imply correlative duties incumbent on the rights-bearer." That is, "Rights in the current understanding are entitlements possessed by individuals who are burdened by no obligations to others."[8] Further, Goodman holds that post-modern rights are distinguished from earlier conceptions of rights, insofar as: (1) the former "are positive claims on the resources of others" whereas the latter "were negative claims to protections against injury by others;" (2) post-modern rights "are absolute and impose obligations upon others—particularly governments," whereas "the older rights were limited by corresponding responsibilities which the holders of those rights were bound to respect;" and (3) post-modern rights "pertain exclusively to the individual, understood in Nietzschean terms as an autonomous, creative self unencumbered by any fixed human nature and related to others only through free choice," in contrast to earlier conceptions of rights which "had a social dimension and implied an obligation to respect the common good."[8] In short, Goodman claims, post-modern rights "represent claims by the individual against society, rather than claims embedded within and emerging from civil society."

These claims he associates with the post-WWII social welfare movement, especially as realized in Europe in the pursuit of a "social market" that seeks "to reduce or eliminate material inequality, even at the price of economic inefficiency and limitations on individual freedom," governments in quest of "the good society" thereby being responsible "for the basic material needs of its citizens." Post-modern rights are, in Goodman's estimation, basically "welfare rights"—which means that "some other party [has] a positive duty to ensure that the rights-bearer could effectively assert his rights," this assertion of rights meaning further that "social costs" are for the most ignored even as one could turn a blind eye to "the resentment of those who were expropriated to allow others to vindicate their claims."[8] These last two consequences are such that Goodman thinks any such assertion of rights to be either a "rhetorical" device that closes off debate and negotiation that

is properly to occur in "the political arena;" or, at best, such assertion of rights is a political matter inappropriately removed from representative legislative and executive deliberations charged with the formulation and implementation of public policy and, alas, transferred to the judiciary "where rulings are handed down from on high," "winner-take-all" and "opportunities for negotiation of differences" foreclosed yet again. In short, complains Goodman, "democratic governance" is weakened thereby.

The problem here, claims Goodman, is that once positive rights are asserted while "divorced from personal or civic responsibility," then they "[give] rise to conflicts over who [is] responsible for making good on the claims they [represent]." Consequently, he contends, "the new welfare rights have brought in their wake a dramatic expansion of government's power over the economy and the lives of its citizens," government thereby acquiring "the power to dictate how they are provided."[8] Goodman finds this consequence undesirable given his commitment to "decentralized, market-based economies where individual workers and employers make independent decisions, based on self-interest," a process of production and delivery of goods and services different from one in which "government assumes the obligation to provide material benefits to others," meaning "it must necessarily appropriate"—better said, "expropriate"—"what others have produced and distribute it to the favored beneficiaries."[8]

Goodman acknowledges it is "hard to gainsay" the assertion that "access to health care should not depend on possession of economic means" or that "a decent society should ensure access to minimum levels of health care regardless of ability to pay." Nonetheless, he reminds us as he looks about for an "authoritative legal text:" "no consensus exists regarding the legal basis of such a right, or the obligations it would impose on governments or the private sector, including health care providers and developers of innovative medicines."[8] As for the application of international law, he adds, "international human rights norms impose obligations solely on governments that sign the legal instruments that contain those norms. They do not obligate corporations or other private entities." Moreover, he asserts, none of the international agreements recognizes a right to health care "at the level of the individual," health being addressed in such instruments "within the context of individual human rights only when obvious damage to health is the primary manifestation of torture, slavery, or some other recognized violation of human rights."[8] Noting Article 12 of the ICESCR, Goodman argues that "the obligations assumed by signatory governments" under this article "relate to public health services, and entail no requirement to recognize an absolute individual human right to health." And, surely, he reminds, "international law gives governments the right to restrict the provision of health care to individuals, which would seem to be incompatible with an individual right to health." This latter point he warrants with reference to Article 4 of the International Covenant on Civil and Political Rights, according to which "the public good can take precedence over individual rights in order to 'secure due recognition and respect for the rights and freedoms of others; meet the just requirements of morality, public order, and the general welfare; and in times of emergency, when there are threats to the vital interests of the nation."[8] The most Goodman allows is that international law expects "that governments will promote better health care for their citizens, especially by facilitating access to basic health services," thus "an aspirational goal for governments, not…an individual human right."

There is a further impediment to recognizing an individual right to health, or even an individual right to health care, argues Goodman, and that is the fact of fast-paced technological innovation: "[No] responsible government could obligate itself on an a priori basis to ensure access to the benefits of future technologies, as might be required under the regime of an individual right to health." Indeed, "Technological development has outpaced the formation of any legal or ethical consensus regarding the definition and content of this right. If such an entitlement were enacted, the ongoing evolution of health technology would force policy makers and jurists continually to reexamine whether the withholding of any particular health intervention would constitute a violation of that right."[8] Perhaps more important from the view of efficiency of a free economy, Goodman maintains, "since governments and other players cannot anticipate the future technological developments that might generate claims under a right to health, such an obligation would commit them to unpredictable and open-ended levels of expenditure"—a commitment Goodman believes any responsible government must reject as a matter of efficient use of available resources and to avoid a consequence not taken into account by proponents of such a right: "Governments would likely respond to the vastly increased demand for health care by imposing new regulatory restrictions on innovators and providers, including price controls and other forms of cost-containment and rationing"—with "negative results for patients'

health."[8] Goodman concludes with the recommendation that while "Governments should certainly do all they can to promote public health and facilitate access to health care resources," nonetheless "they must also respect and preserve the market-based mechanisms that make innovation possible."

SECTION II: FREE MARKET CONSERVATISM

Individuals whose political philosophy is that of free market conservatism claim: (1) "free markets promote efficiency;" (2) "efficiency leads to affluence;" and (3) "the state's primary jobs are protecting rights and fostering affluence," affluence counting as an appropriate measure of economic development and the "general benefit" to society obtained by free market practices of production and consumption.[9] Said otherwise, "a central function of government is to promote prosperity by supporting property rights and the freedom of contract in a free market."[9] On this view, freedom of contract in a free market is the only legitimate basis of economic growth, which is the primary value to be championed by government in securing individual and/or corporate property rights.

Goodman's argument is meaningful only within the context of this value commitment. When he speaks of "expropriation" of resources by government on behalf of the right to health or health care, he could easily have provided the example Peter Wenz references in an international setting, viz., Zimbabwe President Robert Mugabe "seizing land held by white farmers and giving it to unemployed black, landless peasants," the policy and practice "overriding the property rights of wealthy people to provide food-producing land for the poor."[9] Free market conservatives would object to such government intervention or "expropriation" insofar as individual and/or corporate property rights are transgressed, efficiency of operations is diminished, the quality of food products is reduced, methods of production are not improved, and competitive supply of food products is depreciated.[9] These same categories of evaluation are, in the perspective of a free market conservative, pertinent to the production, supply, and delivery of health services, such that acts of expropriation or regulation result in corresponding reductions in the health sector with negative impact on competitive entrepreneurial activity and technological development. The emphasis here, of course, is on what are essentially private goods, to be distinguished from public goods; and what is at issue is whether the right to health references a private good or a public good (though in the case of this right the dichotomy is unlikely to be strictly made, given the way in which determinants of health merge the private and public). I shall attend to this issue in a sub-section of Section III as I discuss one concept of "the just economy" that does not acquiesce in free market conservatism.

SECTION III: THE INTERNATIONAL LEGAL AND MORAL CONTEXT OF INTERPRETATION

A. THE DECLARATORY TRADITION

Goodman's critique raises the issue of compliance and enforcement in international law. It is important to understand that the post-WWII framework of international human rights law is understood to be one of declaratory tradition in contrast, for example, to the earlier, more metaphysical framework according to which "the law of nations" has its origin in and is deduced from natural law. No one has expounded better on the declaratory tradition than Dorothy V. Jones, and so I summarize in brief her exposition of this legal framework. As a point of interjection that links directly to Jones' interpretation, I note a distinction made by Joel Rosenthal. Rosenthal has spoken to the question of standards and distinguishes between "perfectionism" and "non-perfectionism."[10] Perfectionism thinks of "theories of morality based on ideal situations and ideal types;" in contrast, a non-perfectionist theorist works to "build an argument for ethics from the ground up, in a problem-solving mode, searching for principles and standards that can help guide decision-making and action." The declaratory tradition, then, is non-perfectionist but progressivist with respect to moral and legal aspirations that national governments seek to realize in their international and transnational relations. As Terry Nardin reminds, "conceptual languages change through time," so that ethical judgments relative to international affairs reflect a process of evolution of "assumptions," "vocabularies," and the "structure [of] debate."[11] Thus, the contemporary declaratory tradition focuses on the actual behavior of states, be this "in the form of express treaties and pacts, or merely modes of interaction habitually practiced and accepted."[12]

Jones examines this tradition and characterizes it as a "sustained effort" on the part of national governments that "has created a body of reflections and rules that is closer to moral philosophy than it is to positive law."[1] The principles at the core of this tradition "summarize years of thought about the proper relations between sovereign entities…as formalized by jurists and philosophers." Moreover, the "formulation of the tradition has resulted from the efforts and interactions of states of different political systems,

ideological commitments, cultural heritages, and levels of economic development."[1] Thus, to the extent such principles are declared to be universal, it is claimed, international law so conceived "is and can be universal because the conditions that formed and shaped it have become or are becoming universal."[1] And, the conceptual frame is such that it looks "to the future" and towards the realization of a common good, the latter conceived essentially as "respect for human rights and fundamental freedoms."

Jones acknowledges, consistent with Goodman's objection to a right to health or a right to health care, that the declaratory tradition "is not effectively binding on the states, despite their frequent attempts to give it obligatory force by saying that the fundamental principles that underlie the tradition are principles of law" even as "the appeal is almost always to conscience, not to courts."[1] Nonetheless, the fact is that there are now established legal institutions, like the International Court of Justice and the International Criminal Court (not to mention the European Court of Human Rights), that are recognized authorities "for interpretation and judgment" even as there is growing "institutionalized review of compliance." In this sense, then, effectiveness is a matter of progressive performance as state-parties to various treaties, conventions, and declarations submit themselves to processes of adjudication. Let us consider one of the central features of this commitment to institutionalized review for compliance, manifest in various formal instruments in the concept of "non-derogable rights."

B. NON-DEROGABLE RIGHTS

Those who are proponents of a right to health are surely concerned to secure what is claimed by that right; thus, they are presumably concerned to address what are presented as at least morally, if not legally, defensible appeals that have the character of grievance lodged by some party whose right is denied or otherwise limited. "Rarely, however," writes the Norwegian philosopher Reidar Lie, "are we provided with any details about exactly how one should understand particular violations of human rights or exactly how one arrives at recommending a particular action to rectify the alleged violation of a human right"—and this holds especially in the case of a claim of a right to health,[13] as we have seen that claim articulated by Goodman. That is one reason Goodman prefers to speak of a right to health care rather than a right to health per se. But, clearly, here we have an interpretation of the declared right, even as someone like Lie construes a right to health in terms of "mobilizing resources" for health, any claim to such a right being really meaningful only if it in fact mobilizes such resources.

Let us consider first of all what kind of right we may reasonably intend when speaking of a right to health as understood in the framework of international human rights law. Consider the concept of a non-derogable right, sometimes (but incorrectly) identified with what are called preemptory norms of international law or jus cogens norms.[14,15] Lee Caplan clarifies: "Under the normative hierarchy theory, a state's jurisdictional immunity is abrogated when the state violates human rights protections that are considered peremptory international law norms, known as jus cogens. The theory postulates that because state immunity is not jus cogens, it ranks lower in the hierarchy of international law norms, and therefore can be overcome when a jus cogen norm is at stake."[14] The International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social, and Cultural Rights (ICESCR) stipulate a number of non-derogable rights. The UN Human Rights Committee, in its comments interpreting Article 4 of the ICCPR, remarks that,

The enumeration of non-derogable provisions in article 4 is related to, but not identical with, the question whether certain human rights obligations bear the nature of peremptory norms of international law. The proclamation of certain provisions of the Covenant as being of a non-derogable nature, in article 4, paragraph 2, is to be seen partly as recognition of the peremptory nature of some fundamental rights ensured in treaty form in the Covenant (e.g., articles 6 and 7). However, it is apparent that some other provisions of the Covenant were included in the list of non-derogable provisions because it can never become necessary to derogate from these rights during a state of emergency (e.g., articles 11 and 18). Furthermore, the category of peremptory norms extends beyond the list of non-derogable provisions as given in article 4, paragraph 2. States parties may in no circumstances invoke article 4 of the Covenant as justification for acting in violation of humanitarian law or peremptory norms of international law…[13]

Article 4.2 of ICCPR, e.g., specifies: "no derogation" of a human being's inherent right to life; the right not to be subjected to torture or to cruel, inhuman, or degrading treatment or punishment; the right not to be held in slavery or servitude; the right not be imprisoned merely on the

ground of inability to fulfill a contractual obligation; the right not to be held guilty of any criminal offence on account of any act or omission which did not constitute a criminal offence, under national or international law, at the time when the particular act was committed; the right to recognition everywhere as a person before the law; and the right to freedom of thought, conscience, and religion. To say that these rights are non-derogable is to say that no state of public emergency (e.g., armed conflict or declared war, natural catastrophe, etc.) "that threatens the life of the nation and the existence of which is officially proclaimed," provides sufficient reason to deny these rights to persons.[14,16]

What we notice here immediately is that a right to health is not enumerated among the list of non-derogable rights. Are we therefore to assert that a right to health is not to be construed as a non-derogable right as a matter of international human rights law? The fact is that whatever measures a State takes unilaterally to derogate from rights stipulated in the ICCPR "must be of an exceptional and temporary nature"[14] so that rights are preserved to the maximal extent expected by international human rights law even as international humanitarian law becomes applicable in such situations of national emergency. Indeed, the UN Human Rights Committee charged with clarification of the Covenant has stated as recently as 2001, "The fact that some of the provisions of the Covenant have been listed in article 4 (paragraph 2), as not being subject to derogation does not mean that other articles in the covenant may be subjected to derogations at will, even where a threat to the life of the nation exists."[14] Further, "In those provisions of the Covenant that are not listed in article 4, paragraph 2, there are elements that in the Committee's opinion cannot be made subject to lawful derogation under article 4."[14] That said, the UN Human Rights Committee also clarifies that, "Conceptually, the qualification of a Covenant provision as a non-derogable one does not mean that no limitations or restrictions would ever be justified."[14]

Thus, one may propose that a right to health counts as a "fundamental" human right even if it is not enumerated as a non-derogable right, in which case one claiming a right to health may appeal to Article 5.2 of the ICCPR and Article 5.2 of the ICESCR, according to which no State may derogate from or restrict a fundamental human right "on the pretext that the present Covenant does not recognize such rights or that it recognizes them to a lesser extent." Recall that among the non-derogable rights recognized in the ICCPR is the right to freedom of thought, conscience, and religion. Yet, under Article 18.3, a State may unilaterally limit this freedom as a matter of law and as may be "necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others." Any limitation, however, "shall be interpreted in the light and the context of the particular right concerned."[16] Section II.D.60 of the Siracusa Principles provides for juridical review and enforcement: "The ordinary courts shall maintain their jurisdiction, even in a time of public emergency, to adjudicate any complaint that a non-derogable right has been violated." In short, as emphasized in II.E.61, "Derogation from rights recognized under international law in order to respond to a threat to the life of the nation is not exercised in a legal vacuum. It is authorized by law and as such it is subject to several legal principles of general application." Thus, a government's responsibility to protect the public's health is such that the national interest in health may superintend that government's obligation to secure a "non-derogable" individual right such as the right to freedom of thought, conscience, and religion. Stated more specifically, "Public health may be invoked as a ground for limiting certain rights in order to allow a state to take measures dealing with a serious threat to the health of the population or individual members of the population. These measures must be specifically aimed at preventing disease or injury or providing care for the sick and injured."[6,16] Gostin and Mann qualify this point, however: "The human rights impact assessment suggests a balance between the burdens and public health benefits of a policy. In general, broad or intrusive human rights violations are seldom, if ever, warranted. At the extreme, a public health approach that uses an effective means to achieve a compelling public health objective may sometimes warrant a limitation of human rights."[6] Accordingly, Gostin and Mann propose adherence to what they call "the principle of the least restrictive alternative," i.e., seeking "the policy that is least intrusive while achieving the public health objective as well or better than the policy under consideration." The authors maintain: "The human rights community should insist that governments find alternatives that achieve the public health goal without unduly violating rights and dignity."

Note that here public health is construed as the proper concern of government not only for the collective public but also out of concern for individual members of the population. Because there is a state of emergency the State undertakes specific measures to meet that emergency even as a limitation of other non-derogable rights is permitted for the

time of the declared emergency. The argument is one of "strict necessity"[16] due to the extraordinary features of the state of emergency. II.C.53 & 54 of the Siracusa Principles elaborate: "A measure is not strictly required by the exigencies of the situation where ordinary measures permissible under the specific limitations clauses of the Covenant would be adequate to deal with the threat to the life of the nation." Further, "The principle of strict necessity shall be applied in an objective manner. Each measure shall be directed to an actual, clear, present, or imminent danger and may not be imposed merely because of an apprehension of potential danger." If the limitation occurs out of concern for public health, the government acts to prevent disease or injury or to provide care for the sick and injured among the public at large surely, but also to respond to prevent disease or injury or provide care for individual members of the national community. This suggests that government action is grounded in recognition of both a collective right (thus, the "public" health) as well as individual right (thus, individual health). On this line of reasoning, then, such action on the part of government entails recognition of a right to health per se, not merely a right to health care as Goodman would have it. Indeed, as the UN Committee on Economic, Social and Cultural Rights clarified explicitly in their "General Comment" of May 2000, Article 12.1 of the ICESCR "is not confined to the right to health care [my italics]. On the contrary, the drafting history and the express wording of article 12.2 acknowledge 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."[14] The foregoing illustrate but do not exhaust the scope of States parties' obligations under the ICESCR. Indeed, given what it calls "the core obligations" of a State party to article 12 of ICESCR, it is clear the Committee construes the right to health as "non-derogable" at least with reference to the stipulated core (paragraph 47).

C. THE RIGHT TO HEALTH IN THE SPECIAL RAPPORTEUR'S REPORT OF 2006

The UN Commission on Human Rights recognizes a right to health, establishing a mandate of the Special Rapporteur "on the right of everyone to enjoyment of the highest attainable standard of physical and mental health." In his annual report issued recently (03 March 2006), Special Rapporteur Paul Hunt speaks of a right to health as "a right to an effective and integrated health system, encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all."[17] By 'underlying determinants of health' we are to understand basics such as "adequate sanitation, safe drinking water and health education." The concept of access covers "those living in poverty" as well as the wealthy; "minorities and indigenous peoples" as well as majority ethnic groups; "remote villagers" as well as those living in urban areas; "women" as well as men, "children" as well as adults. A system responsive to local priorities entails "inclusive, informed, and active community participation." The Special Rapporteur understands the declared right to health as a "fundamental human right," an integrated health system being "a core social institution" essential to the achievement of that right.[17]

This right is understood in the context of the declaratory tradition of international human rights law with its emphasis on "progressive realization."[17] Consistent with this view, the Special Rapporteur has moved forward with a programmatic effort to identify "right to health indicators," related to "appropriate national targets or benchmarks," thereby to establish "effective, transparent and accessible monitoring and accountability mechanisms"[17] that influence adjustments to health policy, even as it is understood that these indicators "will never give a complete picture of the enjoyment of the right to health in a specific jurisdiction."

It is here that one can link again to Goodman's complaint about affirming a right to health insofar as the pursuit of such a right entails, in his judgment, "expropriation" of the resources of others. The Special Rapporteur makes it clear that, "International assistance and cooperation [are] an important element of the right to health. Donors have a responsibility to provide financial and other support for the policies and programmes," especially for developing countries.[17] I suggest that this responsibility derives, at least in part, from Article 56 of the UN Charter, which obligates Member-States to develop effective international cooperation for the realization of Article 55 which stipulates respect for human rights and fundamental freedoms. This responsibility derives also from the principle that, "All human rights are universal, indivisible, and interdependent and interrelated," a principle asserted in Article 5 of the Vienna Declaration and Programme of Action at the 59th UN General Assembly in 1993 in response to the World Conference on Human Rights that convened in June of that

year.[18]

D. THE NORMATIVE CONTENT OF ARTICLE 12 OF THE ICESCR

The UN Committee on Economic, Social and Cultural Rights has clarified what it takes to be "the normative content" of Article 12 insofar as it stipulates a right to health. It construes this normative content to include: (a) State parties' obligations; (b) violations subject to remedy; (c) implementation at the national level; and (d) obligations of actors other than State parties. Consistent with Goodman's observation, the Committee acknowledges (General Comment, paragraph 9) that "good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health." Likewise, the Committee recognizes there is "individual susceptibility to ill health" relative to genetic and environmental determinants, including individual lifestyles. These facts, however, do not diminish the reality of other determinants that must be engaged, e.g., "resource distribution and gender differences," "violence and armed conflict," population growth, etc. In short, what amounts to a universal, fundamental right will have its diverse, i.e., particular, application or implementation, relative to what the Committee calls "the conditions prevailing in a particular State party" (paragraph 12)—that is, availability of resources relative to level of socioeconomic development, accessibility without discrimination, acceptability relative to standards of medical ethics and cultural rights, and quality.

Here, again, the emphasis is on a progressive realization of the right to health, "a margin of discretion" (paragraph 53) allotted to State parties, no perfectionist approach implied. This is not to deny there are important issues of "indeterminacy and justiciability," as George Smith argued recently: "Prevailing authority holds that violations of both social and cultural rights generally, and violations of the right to health in particular, are not justiciable and thus unsuitable as bases for judicial review because of their very indeterminacy."[19,20] Nonetheless, in addressing State-parties's obligation under Article 12, the Committee asserts (paragraph 31): "The progressive realization of the right to health over a period of time should not be interpreted as depriving States parties' obligations of all meaningful content. Rather, progressive realization means that States parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of article 12." The obligation, in short, is such that it proceeds logically and sequentially in this order (paragraph 33): (1) respect for the right to health; (2) protection of that right; and (3) fulfillment of the right. Accountability for violation of this obligation turns on the manifest "unwillingness"—rather than on the "inability"—of a State party (paragraph 47) to take the requisite action in policies and programs. Thus, the standard for compliance is explicit: "A State which is unwilling to use the maximum of its available resources for the realization of the right to health is in violation of its obligations under article 12."

E. RETHINKING THE PHILOSOPHICAL BASIS OF "THE JUST ECONOMY"

Goodman's position is tenable if and only if one is committed to free market conservatism as outlined above in section II. However, this commitment by no means compels one's assent. In fact, Goodman's position fails to be compelling when one accounts for free market conservatism's distinction of private and public goods as well as the problems of private sector health service delivery in developing countries in particular. Consider once again some comments offered by Peter Wenz in his discussion of public goods in relation to government regulation.

The fact is that any concept of economic practice, including that of free market conservatism, has to account for "the dilemma of selfishness" despite assumptions about the rationality of decision on the part of producing and consuming agents: "In some contexts, selfish attempts to maximize individual returns leave everyone worse off than cooperative behavior does. This reality contradicts Adam Smith's theory of the invisible hand."[9] Indeed, "In many situations, no invisible hand converts selfish behavior into general benefit."[9] These empirical facts point to the importance of realizing the distinct value of public goods in contrast to—though not to the exclusion of—private goods.

Wenz describes a public good as "something good that no one can benefit from unless many others benefit as well," as a good that "cannot be privatized" in the sense that private property may "exclude others." The fact is that the dilemma of selfishness is operative in the health sector as well, precisely as consequence of the permissive features of free market conservatism in its insistence on efficiency and affluence, and sometimes to the detriment of equally important concerns for the achievement of social justice. If, as Wenz puts it, "Selfish people have little incentive to provide or voluntarily contribute to public goods," and it is indeed true that such voluntary contributions are often not forthcoming, then that which is the public good is

depreciated in value and dangerously restricted under conditions that require the public good to be pursued and achieved.

Consider the idea of expecting voluntary contributions to that public good that one takes public health to be. We could certainly expect the market to be structured so that one depends on individuals and corporate entities voluntarily to contribute to public health by way of production and consumption of services and adjustment of individual lifestyle practices conducive to good physical and mental well-being. As Wenz asks in the context of that public good that one takes national defense to be, one could ask in parallel: Will the public health be defended and achieved by voluntary contributions alone? Given the multiple determinants of health, including the genetic, environmental, and personal lifestyle variables associated with the etiology of disease, patterns of disease affecting populations, and rates of morbidity (incidence and prevalence) and mortality as differentiated by age cohorts, the fact is that voluntary contributions alone will not provide the requisite financial and human resources or physical infrastructure for delivery of health services. Neither will voluntary contributions alone provide for fair, non-discriminatory access to and utilization of those resources. This is all the more so in the case of selfish behavior on the part of both producers and consumers of requisite health services. As Wenz observes, "If no one has a private incentive to provide for public goods"—including here public health—then "they will not be provided by private initiative, and so the government must step in to provide them."[9] It is no surprise, then, that WHO reported in 1991 a "lack of evidence to support a generalisable policy of promoting the contracting of clinical service provision to the private sector in developing countries," consequent to "inequities in access," "possible private sector inefficiencies relative to the public sector, and the complexities of developing and implementing national private health sector policies."[21,22]

The point here is that regulation by the price mechanism is inadequate to the public health goals of prevention and remediation of disease. Even a free market conservative such as Friedrich Hayek understands and concedes the point when accounting for public goods—"in such instances we must find some substitute for the regulation by the price mechanism."[9,23] Goodman's analysis ignores this basic fact, made clear in any number of instances of communicable disease processes (infectious and parasitic in particular) wherein prevention as well as remediation are public goods first and foremost. To illustrate the point: It is well known today that malaria is a parasitic disease imposing a "global burden," with "75 percent of all deaths due to infectious diseases" occurring "in southeast Asia and sub-Saharan Africa."[24] This contrasts to 4 percent for the Americas and 2 percent for Europe. Citing World Health Organization data, the Global Health Council reports for 2001 infectious disease deaths as a proportion of all deaths as: 62% for Africa; 31% for Southeast Asia; 11% for the Western Pacific; 34% for the Eastern Mediterranean; 10% for the Americas; and 5% for Europe.[23] WHO reports more than 300 million cases of malaria and over one million deaths from malaria annually.[24] Jeffrey Sachs of The Earth Institute at Columbia University asserts with good reason that restored economic growth in Africa is unthinkable without control of malaria along with AIDS.[25] "Without the control of these two diseases," writes Sachs, "there is little prospect of attracting foreign investment, upgrading technology, building a tourist sector, and raising educational attainments, not to mention saving productive lives…Malaria has arguably been the greatest shackle on Africa's economic development throughout modern history." In short, the main concern of free market conservatives—economic growth—is unattainable for much of Africa in the absence of significant government intervention accompanied by international donor assistance. Left to the free market price mechanism, individual voluntary efforts would not achieve the levels of prevention or remediation needed to reduce either morbidity or mortality due to the disease. The same reasoning applies in any number of infectious diseases.

Notwithstanding the foregoing commentary, the philosophical bases of political economy—including those associated with free market conservatism—are subject to examination and adjustment when those philosophical foundations are related to the demand for justice. One cannot merely assume, as many free market conservatives do, that the achievement of justice is a function of free market performance as measured by economic growth or affluence and efficiency in production and consumption of private goods. Consider the perspective offered by Richard Winfield in his engagement of the question of "the just economy."

As Winfield's discussion makes clear, the fact is that "The economy is an integral domain of justice with its own rightful relations"—at least, this is part and parcel of the modernist perspective, free market conservatism being one such representative.[26] Economic theory on one view may

be "descriptive," yet on another view the underlying rationality of a given economic theory entails a prescription of economic relations. This is certainly so for free market conservatism as is manifest in the position advanced by Goodman in the case of the health sector. Given a "liberal" conception of political economy, "society is civil to the degree it provides a community whose members are able to exercise free choice in disposing over property and pursuing personal interests."[26] That civility is diminished and democratic governance threatened, as Goodman claims, when free choice is supplanted by government regulation. By contrast, one committed to "contractarian autarchy," such as Johann Gottlieb Fichte, holds that the social contract that establishes civil society "must also address the positive task of guaranteeing the assured livelihood of all prospective members of civil society, since otherwise, the insecurity of subsistence will put their liberty in jeopardy."[26] Thus, civil society for Fichte entails a self-sufficient economy with economic relations internal to the contractarian state ordered accordingly. Yet, Winfield points to a theoretical and practical question that has yet to be engaged by one not committing to these positions: "If the priority of freedom is to be the foundation for extending distributive justice beyond the requirements of rational agency to the requirements of a fair conventional standard of living, then the freedom in question must have a more determinate content than liberty of choice."[26] In the case of health sector policy, that means, inter alia, that the explicit (or implicit) prescription of economic relations—manifest in the production and delivery of health service goods and the consumption that follows from availability and access—is by no means a given such as free market conservatives (including Goodman) believe and advocate. Accordingly, a rightful place for governmental intervention relative to public goods may find its reasonable justification in an alternative theoretical conception.

Thus, Winfield writes, "market relations, either alone or supplemented by civil law, economic interest groups, and the private efforts of individuals and households, cannot realize the economic injustice consisting in unequal economic opportunity."[26] For a philosopher like Hegel, government has a right of public regulation that acts to "redeem the market"—ameliorating impediments introduced by the civil economy, "regulating" while not "outlawing" markets.[26] Indeed, contrary to the free market conservative perceptions of public regulation, "economic right equally obliges public authority to…provide sufficient health care" as part and parcel of its obligation to "provide all with the assets allowing them to exercise their market freedom," health care being one among a number of "prerequisites for exercising…economic autonomy."[26]

SUMMARY

BEYOND THE "POST-MODERN" DIVIDE

Our foregoing discussion points to the fact that the declaratory tradition of international law recognizes a right to health per se and not merely a right to health care. Rights of individual persons are recognized even as collective rights are recognized, each of which imposes a host of obligations on national governments in particular. The right to health is a non-derogable right, a fundamental right, consistent with a commitment to fundamental human freedoms. In the context of post-WWII discourse on human rights, it is clear that the right to health is articulated relative to "the tension between liberal states founded on civil and political rights and socialist and communist welfare states founded on solidarity and the government's obligation to meet basic economic and social needs."[27] Thus, the tension is inevitably between a private, free market approach and a government, regulatory approach to engaging the determinants of health. Nonetheless, any defensible conception of a just economy includes public regulation of the health sector in contrast to regulation by market price, especially given the pattern of disease in the developing world.

If one thinks of the core components of the right to health, whether the path to attainment is that of the free market or public sector intervention, the UN estimates "the cost of universal access to basic education, health care, food, and clean water" to be about "$40 billion a year—less than 4 percent of the combined wealth of the 225 richest people in the world."[27] Even if one takes this to be a low figure, or if one is skeptical about the resource requirements relative to claims of resource scarcity,[28] as George Annas comments, it nonetheless "suggests that not much redistribution is required to have a major impact on the lives of most people in the world."

Whether any of this suggests a "modern\post-modern" debate about human rights and a right to heath in particular depends on any number of philosophical orientations that may provide the point of departure and frame of analysis. To characterize the contemporary commitment to the right to health as somehow linked to a Nietzschean conception of human being, as Goodman opines, I think, is mistaken. Postmodern discourse is hardly monolithic and instead is quite varied, even (as in the case of Jürgen Habermas) to the

point of defending Enlightenment ideals against late-modern critiques such as those that emanate from Marx and Nietzsche in particular. Thus, rather than speak of post-modern rights as Goodman does, I prefer to see the task as one of articulating a different discourse.

George Annas points to this task in noting the difficulty we have today in articulating "a global public health ethic."[29] Jonathan Mann likewise reminds of recent events such as the HIV/AIDS epidemic and humanitarian emergencies in Somalia, Iraq, Bosnia, Rwanda, and Zaire, all of which highlight "the long-standing absence of an ethics of public health," indeed the unavoidable linkages between international public health practice and human rights.[31] Ibijiofor Aginam redirects our thinking likewise in urging, "In thinking about human rights we should de-emphasize justiciability and stress human dignity, indivisibility, and the interdependence of all human rights—civil, political, economic, social, and cultural"—human dignity and the indivisibility and interdependence of these rights being "the starting points for a reconceptualization of the right to health."[31] This task imposes itself upon us in the midst of a process of globalization that sharpens the local/global, private/public, liberal/welfare tensions, each with their "pathologies of power" within which individual and collective rights and obligations are sorted out. The reality of globalization itself is such that health professionals in particular need to be wary of "broader governmental objectives for the health sector…sacrificed for the profit motive, either of private providers within countries or of multinational players who dominate particular markets."[32]

We cannot escape palpably structured relations of interdependence consequent to the structural features of the international political order. We must not forget, in thinking about the substance of a global public health ethic, that "violence against individuals is usually embedded in entrenched structural violence."[33] As William Foege remarked rather succinctly, "Global health has always been compromised by institutionalized poverty."[34] And, the fact is that thereby the public health domain cannot but be "vulnerable to ideological deformations" even as those who serve the public health interest pursue any number of imperatives that include prevention and remediation.[34] The imperatives of action remain, for governments and for individuals. If there is any domain of phenomena and human intervention that manifests the limitations of the imaginary geography that separates humanity into sovereign nation-states, it is the public health, conceived today properly as the global public health. But, this is always more than a concept—it is an aspiration consequent to a universal moral imperative that is yet committed to what the philosopher Immanuel Kant appreciated in speaking of the unconditioned good, viz., good will. May human good will prevail, indeed, motivating us to the progressive performance of our duties even as we realize the magnitude of the constraints and restraints upon our actions on behalf of the right to health.

COMPETING INTERESTS AND ACKNOWLEDGMENTS

An earlier version of this paper was presented before the faculty of the School of Public Health at the University of Nevada Reno. I am grateful for dialogue and constructive comments that have contributed to improvement of my extended argument—acknowledging specifically Professor Craig Klugman of the Department of Health Ethics, Policy, and Administration. The views expressed herein are entirely the views of the author. They do not represent, connote, or imply either a concurring view from the institution with which the author is formally affiliated or those acknowledged above.

References

1. Jones, DV: The Declaratory Tradition in Modern International Law. In Traditions of International Ethics. Edited by Nardin T & Mapel DR. New York: Cambridge University Press; 1992/2001:42-61.
2. . Jones, DV: Code of Peace: Ethics and Security in the World of Warlord States Chicago: University of Chicago Press; 1991
3. General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights), UN Document E/C.12/2000/4. 11 August 2000; available at http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument
4. Yach D: Globalization and Health: Exploring the Opportunities and Constraints for Health Arising from Globalization.
Globalization and Health 2005, 1:2
5. von Schirnding Y: The World Summit on Sustainable Development: Reaffirming the Centrality of Health.
Globalization and Health 2005, 1:8
6. Gostin L and Mann J: Toward the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies. In Health and Human Rights: A Reader. Edited by Mann JM, Gruskin S, Grodin MA, Annas GJ. New York: Routledge; 1999: 54-71
7. Goodman T. Is There a Right to Health?
The Journal of Medicine and Philosophy 2005, 30:643-662
8. Wenz PS: Political Philosophies in Moral Conflict. New York: McGraw Hill; 2007
9. Rosenthal J: What the Sages Say. Lecture at the Fletcher School of Diplomacy, Tufts University. Available at Carnegie Council on Ethics and International Affairs, http://www.cceia.org
10. Nardin T: Ethical Traditions in International Affairs. In Traditions of International Ethics. Edited by Nardin T and

Mapel DR. Cambridge: Cambridge University Press; 1992:1-22
11. Forsyth M: The Tradition of International Law. In Traditions of International Ethics. Edited by Nardin T and Mapel DR. Cambridge: Cambridge University Press; 1992:23-41
12. Reidar L: Health, Human Rights, and Mobilization of Resources for Health.
International Health and Human Rights, 2004, 4:4
13. United Nations/Committee on Civil and Political Rights. General Comment on Article 4. CCPR/C/21/Rev.1/Add.11, 31 August 2001
14. Caplan LM: State Immunity, Human Rights, and Jus Cogens: A Critique of the Normative Hierarchy Theory. The American Journal of International Law 2003, 97:741-781
15. United Nations Economic and Social Council: Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, II.D.58: Non-Derogable Rights. UN Document E/CN.4/1985/4, Annex (1985)
16. UN Commission on Human Rights: Economic, Social and Cultural Rights: Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health. Sixty-second Session, Item 10 of the Provisional Agenda, Advance Edited Version, E/CN.4/2006/48, 03 March 2006
17. UN General Assembly: World Conference on Human Rights. Vienna, 14-25 June 1993, Document A/CONF.157/23, 12 July 1993
18. Smith GP: Human Rights and Bioethics: Formulating a Universal Right to Health, Health Care, or Health Protection?
Vanderbilt Journal of Transnational Law 2005:1295-1321
19. Leary VA: The Right to Health in International Human Rights Law.
Health and Human Rights 1994, 1:1. Available online at: http://www.hsph.harvard.edu/fxbcenter/V1N1leary.htm
20. Brugha R and Zwi A: Global Approaches to Private Sector Provision: Where is the Evidence? In Health Policy in a Globalizing World. Edited by Lee K, Buse K, and Fustukian S. Cambridge: Cambridge University Press, 2002: 63-77
21. World Health Organization, The Public/Private Mix in National Health Systems and the Roles of Ministries of Health: Report of an Interregional Meeting, 22-26 July, 1991, Morelos State, Mexico.
22. Hayek FA: The Road to Serfdom. Chicago: University of Chicago Press; 1944
23. Global Health Council: http://www.globalhealth.org/view_top.php3?id=228
24. Sachs JD: Foreword.
Reducing Malaria's Burden: Evidence of Effectiveness for Decision Makers, Global Health Council Technical Report, December 2003
25. Winfield RD: The Just Economy. New York: Routledge; 1988
26. Annas, GJ: Human Rights and Health: The Universal Declaration of Human Rights at 50. In Perspectives on Health and Human Rights. Edited by Gruskin S, Grodin MA, Annas GJ, and Marks, SP. New York: Routledge, 2005:63-70
27. de Groot R: Right to Health Care and Scarcity of Resources. In J.K.M. Gevers, et. al., eds., Health Law, Human Rights and the Biomedicine Convention: Essays in Honor of Henriette Roscam Abbing. Edited by Gevers JKM, Hondius EH and Hubben JH. Leiden: Martinus Nijhoff; 2005:49-59
28. van den Anker C, Widdows H (Eds.): Journal of Global Ethics 2005, 1:1
29. Mann J: Medicine and Public Health, Ethics and Human Rights. In Health and Human Rights: A Reader. Edited by Mann J, Gruskin S, Grodin MA, Annas, GJ. New York: Routledge; 1999:439-452
30. Aginam O: Global Health Governance: International Law and Public Health in a Divided World. Toronto: University of Toronto Press; 2005
31. Kumaranayake L and Sally Lake S: Regulation in the Context of Global Health Markets. In Health Policy in a Globalizing World. Edited by Lee K, Buse K, and Fustukian S. Cambridge: Cambridge University Press, 2002:78-96
32. Farmer P (with Gastineau N): Rethinking Health and Human Rights. In Health and Human Rights: A Reader. Edited by Mann J, Gruskin S, Grodin MA, Annas, GJ. New York: Routledge; 1999:73-94
33. Foege, WH: Preface. In Global Health Leadership and Management. Edited by Foege WH, Daulaire N, Black RE, Pearson CE. San Francisco: Jossey-bass/John Wiley & Sons, 2005:xv-xxv

Author Information

Norman K. Swazo, Ph.D., M.H.S.A.
Professor of Philosophy, Department of Philosophy & Humanities, University of Alaska Fairbanks