Chapter 1

THE UNIVERSAL DECLARATION OF HUMAN RIGHTS

BACKGROUND

Being imprisoned for a lengthy period without trial, everyone would agree, is a violation of human rights. But it would be a joke, and not a very funny one, to assert that your rights had been violated by several months of unexpected foul weather. Is suffering from ill health more like wrongful imprisonment, or more like an inhospitable climate? After all, falling ill is generally assumed to be a matter simply of bad luck, unless, as it often is, it is a result of your own lifestyle choices.

But consider Moleen Mudimu, who died of AIDS in Zimbabwe in 2006. For the last year of her life she suffered terribly; her flesh wasted away, and her body was covered with sores and fungal infections. The anti-retroviral drugs that would have restored her to a decent level of fitness and significantly prolonged her life were available in the pharmacy at the end of
her road. But she was unemployed and had no money to buy them. In any case, purchasing power had been destroyed by the hyperinflation that has been a feature of President Mugabe’s chaotic rule. Zimbabwe’s previously well-functioning health system had collapsed, and although free treatment was available to a few, demand greatly outstripped supply. So she died. She died, it seems, because of a set of other people’s decisions—decisions about the pricing of drugs, patent laws, economic policy, national priorities, and international sanctions. These had structured her environment in a way that made it impossible for her to survive. Paul Farmer calls this “structural violence.” Whatever the cause of her condition, it seems perfectly reasonable to say that Moleen Mudimu’s human right to health was violated.

To say this much is to make a moral claim. But it is a claim that is also supported in international law. Article 12 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR) begins:

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. This covenant, which came into force in 1976, was a way of giving effect to some of the rights set out in the Universal Declaration of Human Rights (UDHR) of 1948, Article 25(1) of which acknowledges a right to medical care.

The Universal Declaration of Human Rights was born out of the trauma of the Second World War. In April 1945, in the last weeks before the German surrender, representatives of fifty nations—primarily the Allied nations that had declared war on Germany or Japan—met in San Francisco with the aim of setting up a new international organization, the United Nations. Some 3,500 delegates, advisers, and staff spent two months drafting the UN Charter and associated protocols. It is said to have been one of the largest international meetings ever to have taken place. The outcome, the United Nations, was designed as an international forum to deal with disputes among nations, to prevent future wars. Notoriously, the general idea had been tried before after the First World War, with the League of Nations, but its failure to preserve peace gave the parties a greater incentive to get the structures right the second time round. US president Franklin Roosevelt felt this especially keenly, and was determined to ensure that the US would ratify the UN Charter, for its failure to do the same thing for the League of Nations had weakened the League beyond hope.

Roosevelt had earlier, in 1941, famously set out what he believed to be the “four freedoms” all humans beings should enjoy: freedom of speech and expression, freedom of worship, freedom from want, and freedom from fear. By the standards of previous declarations of fundamental rights and freedoms, this is an unusual list. Freedom of expression and worship are familiar, but freedom from want and fear stand out as something new. The width of these four freedoms would prove an important inspiration and reference point in drafting the UDHR.

Roosevelt died in April 1945, but momentum began to form behind a human rights agenda for the new United Nations as a shocked world learned of the atrocities of the Nazi regime. Nevertheless, the Great Powers—the US, the UK, and the Soviet Union—were not at all enthusiastic about the idea of an international human rights agreement. After all, the US practiced racial segregation, the UK had a huge, though crumbling, empire, and the Soviet Union had many restrictions on the freedom of its citizens. However, intensive lobbying by Carlos Rómulo of the Philippines, Herbert Evatt of Australia, and philosophy profes-
or Charles Malik of the Lebanese Republic, together with several Latin American states, led to the concerns of less powerful nations and their peoples coming to the fore. Eventually when on June 26, 1945, the UN Charter was completed, it contained provisions for “human rights and for fundamental freedoms for all without distinction as to race, sex, language or religion”—and, crucially, for the foundation of a Human Rights Commission.

Still, it was a long road from the UN Charter of 1945 to the Universal Declaration of 1948. The journey was led through the judicious and inspirational work of Eleanor Roosevelt. But fascinating though it is, this is not the place to retell that story. The points we need to keep in mind are first, that the Universal Declaration has its origins in the shock of the Second World War and in what apparently civilized peoples were capable of doing to one another and to their own citizens, and second, that far from being, as some critics allege, a statement of the principles already followed by the most powerful nations, pressure for universal human rights came from less developed nations. It is amazing that probably every country in the world was, initially at least, in breach of some of the principles it was prepared to endorse.

After innumerable rounds of drafting and redrafting the United Nations finally voted on the Declaration on December 10, 1948. Of the fifty-eight countries that were entitled to vote forty-eight gave their assent, eight abstained—the six members of the Soviet bloc, as well as Saudi Arabia and South Africa—and two were absent. No country voted against, but even more impressively, when the articles were voted on one by one, twenty-three of the thirty were approved unanimously, without abstention. According to Eleanor Roosevelt, the main reason for the abstention of the Soviet Union was that it could not accept the right of everyone to leave his or her country. But generally, the Declaration was much more a testament to the aspirations of the oppressed than it was a protection of the power of the wealthy.

DECLARATIONS, COVENANTS, AND CONSTITUTIONS

Before looking in more detail at the provisions of the Universal Declaration and subsequent covenants, it is worth adding a little more about the origin of another institution which arose in the immediate aftermath of the Second World War, the World Health Organization (WHO). The first chronicle of the WHO, published in 1947, explains its role as an integrated and expanded successor, under the broad framework of the United Nations, to earlier international health organizations. The then pressing concerns facing the international community were expressed in a message of support sent by President Truman to the first International Health Conference held in New York in 1946:

Modern transportation has made it impossible for a nation to protect itself against the introduction of disease by quarantine. This makes it necessary to develop strong health services in every country, which must be coordinated through international action.

However, in its constitution—which it describes as the “Magna Carta of Health”—the WHO takes itself as having a much wider objective than preventing the international spread of infectious disease:

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.\textsuperscript{12}

And health itself is defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

The Universal Declaration of Human Rights, itself, though, has a rather more muted, if nevertheless very significant, statement (Article 25(1)) which reads:

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.\textsuperscript{13}

The Universal Declaration recognizes the right to medical care as a determinant of health and well-being, but falls short of the expansive right to health set out by the WHO: it calls for a standard of living “adequate” for health, rather than the “highest attainable standard of health.” It is worth noticing that the Declaration implicitly at least makes the vital distinction between medical care and health. A right to a particular level of health is not the same thing as a right to a particular level of medical care. For one thing, there are very many determinants of health, such as nutrition and sanitation. Accordingly, it may be possible to achieve high levels of health with relatively little expenditure on medical care, or alternatively, high levels of medical care may not be very effective in achieving decent population health. As the Declaration implies, a commitment to health, ideally, requires attention to those factors that will keep people well, rather than merely on the factors such as medical care that may help restore them to health when they fall sick.

However, the story does not stop here. The Declaration was just that: a declaration. Separate discussions were needed to create a binding covenant, and it soon became apparent that not all countries would be prepared to commit themselves to legally binding economic and social rights, as contrasted with less controversial political and civil rights. In 1954, drafts of two covenants were finally completed, one on civil and political rights and the second on economic, social, and cultural rights. It was not until 1966, however, that the covenants were adopted by the UN, and they did not come into force as a formal part of international law until as late as 1976, when they had been ratified by the required number of countries. The first, the International Covenant on Civil and Political Rights (ICCPR), though highly significant, proved rather less contentious, in protecting individuals from forms of discrimination, oppression, and persecution. It has been ratified by the great majority of nations of the world.\textsuperscript{14} The second, the International Covenant on Economic, Social, and Cultural Rights (ICESCR), has encountered more opposition, and has been ratified by rather fewer countries; indeed, the USA has not done so. But it is this covenant that primarily interests us as it sets out, in Article 12, an elaborate statement of the human right to health:

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.
2. The steps to be taken by the States parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
(b) The improvement of all aspects of environmental and industrial hygiene;
(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.\(^{15}\)

Two years after the Covenants came into force, in 1978, an International Conference on Primary Health Care took place in Alma-Ata, then in the USSR, now in Kazakhstan. The resulting declaration, signed by 134 countries, began by summarizing the WHO position that:

health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.\(^{16}\)

Section 5, however, illustrates the dangers in setting targets, even if they are twenty-two years away:

A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.

The Alma-Ata conference gave impetus to the right-to-health movement, which was beginning to find its feet.\(^{17}\) What, though, should we say about countries that have not ratified the conventions? Consider, for example, a country that has not ratified the Covenant on Civil and Political Rights. Suppose we then find it is torturing members of the political opposition, and that the international community voices strong protest about human rights abuses. It would hardly seem an adequate response if the president of the country were to respond that the opponents are making a simple legal mistake: human rights conventions are not binding on countries that have not ratified them, and so there are no relevant human rights to violate. Rather, we are likely to believe that such rights now form part of what can be called “international customary law”: morally and legally binding on all countries once there is significant international weight behind them, whatever an individual state’s attitude. In this view, human rights conventions are binding on all nations in the way in which domestic law is binding on all citizens, whether or not they have personally consented to those laws.

PROGRESSIVE REALIZATION AND CORE OBLIGATIONS

The human right to health is now an established part of international law. Yet looking at the terms in which these declarations and conventions are stated, one may be filled with a sense of hopelessness. What could it mean to guarantee to all the people of the world “the right to the highest attainable standard of health,” especially according to the WHO definition of “complete physical, mental and social well-being”? Does everyone in the world have the right to the health and life expectancy of the
Japanese, who currently, as a nation, have the longest life expectancy? How could that be achieved? And do even the Japanese enjoy “complete physical, mental, and social well-being,” especially in light of natural events beyond human control such as the earthquake and tsunami of March 2011? Without a huge increase in budgets, which is not in prospect, attempting to provide everyone with even a more modestly defined right to health could drain resources from other vital areas, such as education and housing. Many critics will view such conventions as no more than fine words and sentiments.

In recognition of the difficulty of resource constraints, the ICESRC adopts the notion of “progressive realization” rather than “full immediate realization” of the rights. In 2000 this was further clarified when the Committee on Economic, Social, and Cultural Rights issued the very important General Comment 14 to explain how the human right to health can be approached in practice. The committee, which was constituted in 1985 to monitor compliance with the ICESCR and to issue guidance on its interpretation, understood the difficulties of the task, acknowledging, in Article 5, that the full enjoyment of the right to health is a “distant” and in fact “receding” goal for many millions of people.

Accordingly, General Comment 14 states that the right to health is not the right to be healthy (Article 8). Nevertheless, the right to health is not merely the right to medical care, which is merely one of the many determinants of health. Healthy living and working conditions, for example, are just as vital (Article 11).

The most important issue is that of resource constraints, and it is accepted that there can be legitimate reasons why a state may not be able fully to realize the right to health. Hence the committee adopted the language of “progressive realization,” which means that a country must take planned and targeted steps toward full realization, but cannot be criticized for not immediately achieving the highest standard of health for its people if that is not attainable. General Comment 14 insists that:

30. . . . States parties have immediate obligations in relation to the right to health, such as the guarantee that the right will be exercised without discrimination of any kind (art. 2.2) and the obligation to take steps (art. 2.1) towards the full realization of Article 12 [of the Covenant on Economic, Social and Cultural Rights]. Such steps must be deliberate, concrete and targeted towards the full realization of the right to health.

The earlier General Comment 3 had clarified the notion of a state’s “minimum core obligations.” In the present context, this instructs that states must use whatever resources they have to supply essential primary health care. The position, however, remains somewhat confusing. “Progressive realization” permits a country’s limited resources to provide a valid excuse for limited progress to full realization, whereas the notion of “minimum core obligations” suggests that there is no excuse for failing to achieve a particular level of health care. It may seem that these ideas flatly contradict each other. A very poor country may not be able to provide even basic primary care for all. Does it thereby breach the human right to health of its citizens? But if it can do no more, what purpose can be served by accusing it of human rights violation (as General Comment 3 tacitly admits)? Or is the point that it must seek international assistance, and in signing up to ICESRC wealthy nations have accepted their responsibilities to assist poorer nations in meeting their minimum core obligations? This, in fact, is what General Comment 14 suggests. But it raises one of the central philosophical and legal questions regarding the doc-
truc of human rights. It is all very well to argue for universal human rights, but who or what has the responsibility to meet those rights, especially when it can be very expensive to do so? This question will preoccupy us throughout this book.

One further development is of particular interest. In 2005, General Comment 17, on the right to benefit from scientific progress, was issued. The committee accepted that there is a human right to benefit from intellectual production, but at the same time points out that particular regimes of copyright law are constructed for social benefit. A pressing concern regards general access to patented medicines. Do states have an obligation to protect intellectual property even if this means that thousands may die prematurely? This, of course, has become the issue of “access to essential medicines” which will also be a recurring theme in this book.21

In summary, the human right to health is now a well-established part of international law, although with some elements in need of further refinement, especially concerning the ideas of progressive realization and core obligations. Having the human right to health inscribed in international law is a vitally important achievement. But it is not enough to silence all critics. What, after all, are the moral foundations of the human right to health? And what does it call for in practice? We will take up these important questions in the next chapter.
as the right to education, or, indeed, the right to health. Most of these duties will, in the first instance, fall on the state, and ultimately on the burdened taxpayer.

The argument, however, that first-generation rights are cheap and easy to enforce, and second-generation rights prohibitively expensive, has now been thoroughly discredited. The cost of enforcing rights of non-interference can be enormous. For example, each of us has human rights to liberty and security. The state has a duty not to undermine our liberty and security, but also to protect us from violations of these rights by other citizens. Such protection requires criminal and civil justice systems with vast resources devoted to the police, the law courts, and prisons, not to mention the military. It may well be cheap for the state not to interfere, but not at all cheap for it to stop others from doing so, and to provide systems of punishment and compensation. The real reason for a reluctance to endorse second-generation rights is probably an ideological position that it is not for the state to guarantee extensive economic and social rights for its citizens.

In addition, some theorists have worried about “rights inflation.” As first-generation rights, such as the right to freedom of speech and against arbitrary arrest, are so very important, it could be a mistake to add other rights, as the more rights there are the more devalued the currency of rights will become. If the notion of a human right is stretched thin, so it is alleged, no human right will be taken seriously. And yet another source of reluctance is vagueness. What do the second-generation rights actually call for in practice? To take the example that is our subject here, what can the right to health—the right to the highest attainable level of health—actually mean?

Given these problems, insisting on a right to health looks like a hard road to travel. Why attempt it? The global burden of disease is immense, but many moral arguments are available to support calls upon governments and international organizations to act. Human beings already have moral duties of charity and of humanitarian assistance. Why, then, complicate matters by talking about rights to health?

But rights can make a difference. The key point is that rights concern the distribution of power and status. Those with rights have enforceable claims, and need not rely simply on the goodwill of others. By contrast, to need humanitarian aid is often taken as a sign of weakness and dependence while to be able to offer it is a sign of strength and superiority. There can be little better illustration of this than the perhaps apocryphal story of Soviet Union schoolchildren in the 1970s being encouraged by the authorities to donate their kopeks to provide charity for the downtrodden poor of the USA, as a way, most likely, of presenting an image of a particular world ranking of states.

The distinction between rights and humanitarian aid is important. Humanitarian aid is, in a sense, conservative: it conserves existing power structures, whereas to recognize another’s rights is to cede authority to them, at least within a particular sphere. And who knows, they might use that authority in ways in which you’d rather they didn’t, for example as many postcolonial states did when they finally gained independence and had the chance to elect their own governments. For this reason, one can see why powerful states, though they might be perfectly happy to offer humanitarian aid, may wish to stop short of recognizing the rights of countries or peoples that are in a dependent position.

Rights arguments are also more powerful in that while humanitarian arguments typically address only temporary urgent needs, rights arguments can also concern broader structures of liberties and opportunities. Although nothing is infal-
liable, the point of establishing rights is to try to rebalance the power relationship, and to produce long-term, reliable structures that will remove the need for humanitarian concern in the future. That, at least, is the hope, and that is why rights are worth pressing for, even when humanitarian aid is, for the moment, forthcoming.

**RIGHTS AND HUMAN RIGHTS**

These last comments primarily concerned relations between states. Yet the same points apply to a government’s relationship to its citizens. Rights give permanence and power, whereas humanitarianism seems uncertain and temporary. We are all better off and more secure with rights to government action rather than hoping for the government’s continued goodwill. But we now need to turn to the more detailed question of the difference between a right and a human right, especially in relation to health.

Many slip between rights talk and human rights talk without marking the difference, as from time to time we will do in this book. Legally, of course, human rights could be thought of as simply those rights declared to be human rights in international treaties and declarations. But in the drafting of the Universal Declaration on Human Rights it became clear that something else was at stake. Essentially human rights have a double role. On the one hand, they provide a statement of the minimum moral obligations owed to human beings simply by virtue of their existence as human beings. On the other, they generate a mechanism of accountability beyond the nation-state. If a country violates the human rights of its citizens, then those outside national boundaries should sit up and take notice. To

enshrine something as a human right is to open up the internal affairs of a country to international scrutiny. As one of the leading drafters of the UDHR, Charles Malik, of Lebanon, put the point in a speech to the United Nations General Assembly on the day the assembly was to vote on whether to adopt the Declaration: “I can agitate against my government, and if she does not fulfill her pledge, I shall have and feel the moral support of the whole world.”

To say that human rights make a country accountable to the international community does not yet say what form that accountability should take. At one end of the scale, it is a matter of “opening the books” through forms of audit, report, or inspection. At the other end, for very serious human rights violations, it may even be that military action will be called for. And in between there are many other mechanisms. “Naming and shaming” is a popular approach in relation to the human right to health, used, for example, by the French organization Médecins Sans Frontières and the US-based Physicians for Human Rights, which has publicized harms to health experienced in, for example, the Chilean dictatorship, Israel’s occupation of the West Bank, and the first Gulf War, using such techniques as epidemiological studies and DNA analysis of mass graves. Other possibilities include diplomatic communications, sanctions, and, most importantly, positive assistance.

Contrast the international function of human rights with rights granted by a government on such things as pensionable age. In the UK, as I write, citizens are entitled to a state pension at the age of sixty-five. This is a right. However, the government has recently introduced a change to the law so that in the future pensionable age will rise, and it is likely that further changes will adversely affect current workers. Some people may feel that in changing the law in this way the government is ignor-
ing, perhaps even violating, the rights of its citizens, and trade unions have started to campaign on this basis. But whether the pensionable age in the UK is sixty-five, sixty-six, sixty-seven, or sixty-eight seems to be a matter purely for the UK to decide. It is none of the business of the international community. However, if the UK allowed its elderly citizens to live in squalor, it seems plausible that the international community should be entitled to start asking questions, and, if the answers are unsatisfactory, express its disapproval. Hence, one may say, this is evidence that there is no human right to a pension at any particular age, but that there is a human right to dignified retirement and old age. If a government ignores its obligations, such as by allowing state and private providers of care homes to treat elderly people with contempt, or leave them in degrading conditions, it can justly be subject to international scrutiny and censure.

PHILOSOPHICAL CHALLENGES

As we noted, the covenants are full of fine words. But do they really have substance? Although the language of human rights is relatively new, the idea of a human right is closely related to the older notion of a natural right. John Locke (1632–1704), one of its most powerful philosophical advocates, set out to refute the feudal idea that, in effect, human beings were subjects, not citizens. In the feudal view, any rights enjoyed by individuals are granted by their superiors, who in turn received their title from the king or sovereign. The sovereign, appointed by God, ruled by divine right, and had the right of arbitrary power over all of his subjects. Nothing the sovereign did, in this view, could be understood as a violation of the rights of his or her subjects. Locke aimed to establish the truth of the reverse of this: human beings have natural rights that even the sovereign must respect. Furthermore, sovereign power was granted only through a social contract with the people, and if the sovereign overstepped the limits set out by the natural rights of the people, rebellion could sometimes be justified. Hence, Locke suggested, human beings have natural rights to “life, liberty and estate.”

The doctrine of natural rights is one foundation of modern liberal democracy, and is credited with influencing the constitution of the United States, and the ideas that underpinned the French Revolution. Yet the doctrine of natural rights in turn suffered radical criticism. Notoriously, Jeremy Bentham, commenting on the French Declaration of the Rights of the Man and of the Citizen (1789), argued that “natural rights is simple nonsense . . . natural and imprescriptible rights . . . nonsense on stilts.” (By “imprescriptible” Bentham probably meant “inalienable,” i.e. rights that cannot be waived by their possessor or taken away.) Bentham’s argument was that “rights are the child of the law,” and so a natural right—a right prior to the law—was a nonsensical idea, strictly speaking self-contradictory.

Arguments like these are uncomfortable and will worm away at us unless we address them properly. What, after all, are the foundations of human rights? What are the arguments for believing in them? In fact, there are many arguments: that they are based on our common humanity, or on human dignity, or on our nature as human agents, or on our basic needs, or even on God’s will. Our problem is not that there are no foundations for human rights, but that there are too many. Which is the correct account of the foundations? We are unlikely to be able to find a conclusive, universally convincing, single argument or account.

This, however, repeats a debate that took place in the context of drafting the Universal Declaration. For what is as true
now as sixty years ago is that there is much greater agreement on the broad list of human rights than there is on their moral foundations. Of course, there are disagreements about content, but the convergence on doctrine is remarkable, given the divergence on foundations. Jacques Maritain, a French philosopher who played a role in the preparations for the Declaration and observed many drafting meetings, famously commented:

During one of the meetings of the French National Commission of UNESCO at which the Rights of Man were being discussed, someone was astonished that certain proponents of violently opposed ideologies had agreed on the draft of a list of rights. Yes, they replied, we agree on these rights, provided we are not asked why [emphasis in original].

To use terminology from political philosopher John Rawls, the Universal Declaration of Human Rights may be seen as analogous to Rawls’s idea of an “overlapping consensus,” in which each person can endorse a political doctrine for his or her own moral reasons. In sum, then, there are many moral reasons for human rights. People can agree on the Universal Declaration, but they endorse it for a whole range of moral reasons. This, perhaps, explains the appeal of human rights doctrine within a broadly liberal framework, in that it does not presuppose that everyone accepts the same basic moral theory.

But what do we do about residual differences in interpretation? The “overlapping consensus” is far from perfect. At the level of detail there is no consensus. Probably the right response at this point is simply to acknowledge the limits of philosophical argument, and allow the resulting disputes to be resolved through the development of democratic politics and legal doctrine.

A quite distinct line of opposition to rights-based arguments, associated with Hegel and Marx and with communitarian and feminist thought, suggests that there is something wrong with any culture in which people express their moral relations to one another in terms of rights. For, so the argument runs, a rights-based moral discourse presupposes a society of conflict and disagreement that we would do well to avoid. It is only necessary to claim a right if there is a potential or actual dispute.

While it is hard to deny that having no conflict would be a superior way to live, in practice we are stuck where we are, in a society where, sadly, there is conflict over many things, and especially the use of resources. Hence, like it or not, we need rights to navigate our way through competing claims. Still, the objector has a further point to make. While it is true that we may well need rights, nevertheless, we have a choice as to how much we rely on rights claims in making our arguments. A quick recourse to rights will heighten the sense of conflict and encourage a legalistic culture in which people encounter one another as opponents, rather than as fellow citizens. If I think you have something that belongs to me, I could politely ask for it back, or I could instruct my lawyer to serve a writ on you for its return. A society where people routinely do the latter is highly unappealing. But nevertheless, in the world in which we live, conflict exists and assertion of rights, however regrettable, is sometimes indispensable.

A more common criticism is that human rights are an extension of values appropriate to some regions of the world but not all. In particular, it is sometimes said that the doctrine of human rights is a Western notion and there is something suspect, even imperialistic, in attempting to apply it to the entire world as a whole.

This objection was of pressing concern to the drafters of the
Universal Declaration of Human Rights, and, notoriously, it was expressed in forceful if rather condescending terms by the American Anthropological Association in a submission to the commission:

How can the proposed Declaration be applicable to all human beings, and not be a statement of rights conceived only in terms of the values prevalent in the countries of Western Europe and America? . . . If we begin, as we must, with the individual, we find that from the moment of his birth not only his behavior, but his very thought, his hopes, aspirations, moral values which direct his action and justify and give meaning to his life in his own eyes and those of his fellows, are shaped by the body of custom of the group of which he becomes a member. The process by means of which this is accomplished is so subtle, and its effects are so far-reaching, that only after considerable training are we conscious of it.17

The AAA did not go as far as recommending that the drafters give up their task. Rather, it recommended that the Declaration give great emphasis to cultural difference and the right of people to live in accordance with the moral understandings of their own group. And much later, in 1999, the AAA issued its own declaration, which endorses other human rights declarations and conventions while helpfully noting that “Human rights is not a static concept. Our understanding of human rights is constantly evolving as we come to know more about the human condition.”18 The American Anthropologists, then, have come to accept the UDHR as a basis for their own position, and thus have satisfied themselves that the doctrine of human rights need not be seen in terms of Western imperialism.19

Concerns of cultural imperialism will never entirely be put to rest.20 Although the drafting committee included representa-

tives from many countries of the world, there were no representatives from sub-Saharan Africa, with the exception of (white) South Africa. Furthermore, several of the representatives of non-Western countries were people who had lived or studied in the West and so may be treated with suspicion. This chink of vulnerability has led to a more recent attack on the doctrine of human rights as privileging “Western values” over “Asian values.”21

The “Asian values” issue came to prominence in 1993 when countries such as Singapore, Malaysia, and Indonesia, who had been Cold War allies of the West, joined with over thirty other Asian states in a conference in Bangkok prior to the landmark World Congress on Human Rights taking place later that year in Vienna. The Bangkok conference gave rise to a declaration which, while reaffirming strong commitment to the UDHR, enters some qualifications. After several clauses of apparent enthusiastic endorsement of the international human rights regime, the following appears:

Noting the progress made in the codification of human rights instruments, and in the establishment of international human rights mechanisms, while expressing concern that these mechanisms relate mainly to one category of rights.

This cryptic comment is not explained, but soon after there appears a subtly worded trio of observations:

Reaffirming the principles of respect for national sovereignty, territorial integrity and non-interference in the internal affairs of States,

Stressing the universality, objectivity and non-selectivity of all human rights and the need to avoid the application of dou-
able standards in the implementation of human rights and its politicization,

Recognizing that the promotion of human rights should be encouraged by cooperation and consensus, and not through confrontation and the imposition of incompatible values...²²

Further on, the document places emphasis on economic development and trenchantly draws attention to the gap between wealthy and poorer nations as an obstacle to the enjoyment of human rights. However, there is little sign of the affirmation of values that are contrary in spirit to those of the human rights movement. Indeed, the declaration goes on to reaffirm the human rights of women and children in terms that are perfectly consistent with many other human rights declarations. Still, there are further elements of the declaration that are in stark contrast to the general understanding of the role of human rights, most notably:

4. Discourage any attempt to use human rights as a conditionality for extending development assistance;
5. Emphasize the principles of respect for national sovereignty and territorial integrity as well as non-interference in the internal affairs of States, and the non-use of human rights as an instrument of political pressure;

If, as we have suggested, the whole point of a doctrine of human rights is to open up the internal affairs of a country to forms of scrutiny and persuasion by other countries and their citizens, then to take these ideas seriously is really to abandon the doctrine of human rights. The general tenor of the document is to affirm a role for international cooperation in provid-

ing economic and technical development assistance, but to ward off international attempts to “police” human rights. It also hints at the hypocrisy of the developed nations. In partial support of this last allegation we should note that it was only as late as 1992, one year before the Bangkok Declaration, that the US had ratified the International Covenant on Civil and Political Rights, and it did so with so many reservations and exceptions that the Covenant is often considered to be effectively unenforceable with respect to the United States.

At the Vienna conference itself, the “Asian values” debate was given sharper focus, with numerous forcible interventions by representatives of East Asian countries. According to one observer, the foreign minister of Singapore warned that “universal recognition of the ideal of human rights can be harmful if universalism is used to deny or mask the reality of diversity.”²³ Going much further, the spokesman for China’s foreign ministry is said to have asserted that “individuals must put the state’s rights before their own.”²⁴

Here, perhaps, we see an elucidation of the earlier comment from Bangkok, that human rights instruments have concentrated on “one category” of rights: those of individuals, leaving out the rights of states. It seems to be implied that Asian values require much more attention to the rights of states, even at the expense of the rights of individuals.

Amartya Sen provides a fascinating, and very measured, response to this combination of criticisms. He points out that it is, in a way, naive and Eurocentric to generalize about “Asian values.” Asia represents 60 percent of the world’s population and contains many diverse traditions, religions, and cultures. Furthermore, any individual may well have multiple identities and allegiances.

Sen elegantly argues that in all traditions—East and West—
the elite have always asserted their right to freedom. The modern drive of Western liberalism is to try to spread such freedom throughout society as a whole. Sen finds considerable evidence that the ancient philosophical traditions of China, and even more so India, are complex and contain traditions of freedom and toleration alongside traditions of authoritarianism. In this respect they barely differ from Western traditions.25

To return to the Bangkok Declaration, part of its argument is that the needs, rights and liberties of the peoples of the East have been ignored by powerful Western states. This, though, is not an argument against the Western values of human rights. Rather, it is an argument for their application on a non-hypocritical basis; the Bangkok Declaration itself warns of a “double-standard.” The letter of the Universal Declaration, as we saw, is one of protection of the weak, not of the privilege of the strong, and the Bangkok Declaration is a reminder of this essential point. The other major issue hinted at by the authors of the Bangkok Declaration, and forcefully reasserted in Vienna, is that the Asian states greatly resent interference by other countries in their own affairs. But then, they are hardly alone on this matter. One would not say that the United States welcomes outside criticism, pressing very hard on the idea of its own sovereignty, and is not at all open to the idea that it should be held accountable for alleged human rights abuses, such as claims that it has used methods of torture. Yet we need to keep reminding ourselves that the whole point of human rights is to provide a counterbalance to state sovereignty, as, tragically, was absent in Europe in the 1930s and early 1940s. This will always be uncomfortable, especially for those in power, but it is precisely why there is no room for a declaration of states’ rights in a declaration of human rights.26 The peoples of Asian states need, and are entitled to, human rights as much as people from

the West. Nevertheless, as the American Anthropologists insist, there is considerable room for different countries to implement human rights in ways that are most culturally appropriate.

**GENERAL COMMENT 14**

Before looking in detail at real-life questions of the human right to health, it will be helpful to look a little more at General Comment 14, which we introduced in the last chapter, to understand in more detail how it attempts to clarify what the human right to health means in practice.

We have already identified some of the key features of General Comment 14, such as the ideas of progressive realization and core obligations, and we have noted that the right to health is not the right to be healthy, for no one could have that right. Contingencies of biology and life mean that we are all vulnerable to illness, whatever resources we have available. At the same time, the right to health is not merely the right to medical care, for this is only one of the many determinants of health. The right to health seems to stand somewhere between the right to medical care and the right to be healthy. What, then, could it be? Philosopher Henry Shue has clarified the idea of a human right as giving protection against a series of what he calls “standard threats.”27 The human right to health, then, gives individuals protections against “standard threats to health”: a vague idea, perhaps, but one that at least provides a focus for discussion.

General Comment 14 can be seen as elucidating the standard threats against which everyone should be guaranteed protection. In effect, it sees the right to health as constituted by a series of obligations on governments, and the document helpfully sets out a number of what it calls “interrelated and
essential elements” that underpin the right to health. These elements describe the features of a well-functioning health system. First, there is the element of Availability. Naturally enough, this suggests that public health and health care facilities must be sufficient in number to meet the needs of the population. It is explicitly stated that such facilities include not only hospitals, clinics, essential medicines, and adequately paid medical staff, but also safe drinking water and adequate sanitation.

Next comes Accessibility, which in this case is split into four dimensions: non-discrimination; physical accessibility in the sense of being in safe physical reach (including water and sanitation); economic accessibility, in the sense of affordability, for all including the economically most disadvantaged; and “information accessibility,” concerning the provision of health-related information to the general public. The element of accessibility is very wide-ranging. For example, it is sometimes noted that in parts of the developing world many people have to travel some distance to access water and toilet facilities. Often the routes are unsafe, particularly for women and girls, and leave them vulnerable to attack and sexual assault. There are many things that can be said about such a situation, but among its many failings, General Comment 14 makes clear that it is a violation of the government’s duty to protect the human right to health.

The third element is Acceptability, which requires that medical facilities and services meet standards of medical ethics, and are “culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, and sensitive to gender and life-cycle requirements”: a complex matter. The fourth and final element, naturally enough, is Quality; doctors must be well-trained, machinery should function properly, medicines must not be past their use-by date, and so on.

It is one thing to lay out the elements of an ideal system, and another to understand how those elements are to be achieved. General Comment 14 also attempts to specify what governments must do in terms of concrete action. As human rights doctrine evolved, it has become common to divide government obligations into three types: the duty to respect, the duty to protect, and the duty to fulfill. General Comment 14 follows this pattern. The “respect” element concerns a series of direct relations between the government and its citizens. Governments should not discriminate in offering medical and health-related services, by, for example, excluding members of an ethnic minority from health care. Governments should not impede traditional medicine, or allow the marketing of unsafe drugs. They should not force coercive treatments upon people except in some cases of mental illness or communicable disease. They should refrain from limits on contraception and they should not withhold health-related information. They should not pollute the environment or test nuclear weapons if this leads to unsafe release. And they must not limit health service access as a punitive measure.

The longer a list, the more problems there are likely to be. For example, if a government believes that a traditional medicine is unsafe, it appears to have conflicting duties. And though many would agree that restricting access to contraception is to breach human rights, this is hardly universally shared. These examples remind us again that not everything is settled within human rights doctrine. However, although many of these provisions seem bland and unexceptional, it is not until one looks at what might be taken for granted that it is possible to see that many breaches of the human right to health may not even be noticed. For example, is it always the case that prisoners are provided with access to health services on the same terms as other citizens? Although in some countries, paradoxically, it
may be easier to obtain medical attention when in prison than outside, still it may be part of the mind-set of prison guards and governors that prisoners should be allowed to suffer greater health problems than others as part of their punishment. But according to General Comment 14, to deny treatment for punitive purposes is to breach human rights. And the requirements of non-discrimination are interesting too. For example, many countries like to concentrate highly equipped hospitals in urban centers, which can mean diverting resources from elsewhere. Does this discriminate against those who live in rural areas? Respecting the right to health is not a straightforward matter.

The second wave of duties comes under the heading of the duty to protect. This places duties on the state to ensure that no other party interferes with the citizen’s right to health. Examples include ensuring that private health provision does not undermine equitable access for all, and the licensing and regulation of medical professionals. It also includes protection from “harmful social or traditional practices,” and, to quote:

States are also obliged to ensure that harmful social or traditional practices do not interfere with access to pre- and postnatal care and family-planning; to prevent third parties from coercing women to undergo traditional practices, e.g. female genital mutilation; and to take measures to protect all vulnerable or marginalized groups of society, in particular women, children, adolescents and older persons, in the light of gender-based expressions of violence.

This, of course, is a minefield. Some have argued that what the General Comment calls “female genital mutilation”—which, they say should be described in more neutral terms as “genital cutting”—is a legitimate cultural practice and therefore its pro-

hibition is a violation of other human rights. Similarly, many have argued from a religious perspective that contraception, and even more so, abortion, are morally unacceptable, and so not only is it right to restrict access to services and information about them, but it is even wrong to offer them. Once more, this shows that there are controversies even within human rights doctrine, and it may be wondered if the committee was sensible or entitled to take such a bold line on a controversial question, whether or not one agrees with the line it takes. The United States, for example, has complained that General Comment 14 has expanded the human right to health beyond its initial basis in an arbitrary and unaccountable fashion. According to the US:

General Comment 14 . . . expresses the opinions of individuals acting in their private capacity, and is not the result of deliberations among States. The United States does not consider these types of documents to have any standing in international fora.28

We have seen, then, how General Comment 14 deals with the obligations to respect and protect. Next we must explore the duty to fulfill, which sets out a whole series of positive obligations for states, beyond anti-discrimination (respect) and safeguarding against the interference of third parties (protect). The basic idea of the duty to fulfill is, of course, to give effect to the right to health in national, political, and legal systems. This will include adopting a national health policy, as well as providing the appropriate range of services that meet the criteria for “availability, accessibility, acceptability, and quality” set out above. Special care is taken to point to neglected groups that often suffer from poor protection of human rights. These include women, children, older persons, indigenous people, and
people with disabilities—indeed, virtually everyone who has limited access to the instruments of power within a society.

In terms of international obligations, as one would expect there are references to the obligation to provide economic and technical assistance, especially in the face of the gross health inequalities in the world, both within countries and between them. But this is not all. Just as states have the “duty to respect” and the “duty to protect,” so does the international community. No state should take action that undermines the health of the people in other states; explicitly mentioned is that no state should impose embargoes on the supply of medicine or medical goods to another. Furthermore, states have the obligation to prevent third parties from taking steps that would undermine the right to health in other countries. Most importantly, there is an explicit reference to international financial organizations, especially the World Bank and the International Monetary Fund, which have been accused of insisting on economic policies that have weakened health systems and been detrimental to health in their client states. Even more expansively, the General Comment declares that there is a duty on states to provide humanitarian and disaster relief in emergencies to the limit of their capacities, and that while only states are parties to the international agreements, all people, organizations, and private companies also have responsibilities in respect of realizing the right to health.

These, then, are the duties to which the Committee on Economic, Social, and Cultural Rights considered states to be committed in order to realize the highest attainable standard of physical and mental health. But to what extent do countries follow these requirements? In a landmark article in *The Lancet* in 2008, Paul Hunt, then just ending his term as United Nations Special Rapporteur on the Human Right to Health, and colleagues attempted to provide a methodology to assess the degree to which different countries of the world could be said to be realizing the right to health. They surveyed 194 countries by means of seventy-two indicators. One unsurprising finding was that, for many of the indicators, what they called “globally accessible” data was simply not available. Examples included whether the state undertook a health impact assessment before adopting its national health policy, and whether human rights training is a compulsory part of the curriculum for doctors or nurses. It is not that no country does this, but rather that no country makes it easy for people to find out. For some countries very little accessible data could be found, although those countries that have recently been the subject of WHO assistance often had more information available than wealthier countries.

The *Lancet* paper is a fascinating snapshot of the state of the realization of the right to health around the world, although methodologically, critics question whether the human right to health is clear enough to make it possible to monitor compliance. General Comment 14 is far from precise at the level of detail. Although some of the questions are obvious to ask in relation to health—life expectancy, per capita expenditure on medicine—it is unclear what the “correct” answer is. How much should expenditure be in order to be compliant? Other questions are much more procedural, such as whether the civil registration scheme of the country collects data disaggregated by sex, ethnic origin, rural or urban residence, socioeconomic status, or age. Other indicators address the determinants of health, such as access to clean water or the prevalence of violence against women, and indeed the survey starts rather bluntly by asking how many international treaties that recognize the right to health has the country ratified, and, secondly, whether the right to health has been recognized in domestic
law. What is particularly interesting for us in this chapter, however, is the emphasis on national health strategy and planning within the survey. Clearly the authors take the idea of progressive realization very seriously. While it would be unrealistic to think that many countries of the world are able to come close to full realization of the right to health, if indeed we can understand what that idea means, the survey is especially keen to monitor whether or not countries can be said to be making a serious attempt at progressive realization through the formulation of appropriate plans.

Reading the *Lancet* report, one is struck by the immense effort that must have gone into producing the data it relies on. The human and other resources spent simply collecting figures, and, indeed, the underlying planning that is being monitored, may look like a huge bureaucratic exercise. Yet in noting this we see one of the paradoxes of large organizations. Everyone, it seems, is in favor of accountability. But accountability requires bureaucracy, and, it also seems, everyone is against that. Now, of course, although bureaucracy is necessary for accountability it is not sufficient: it will not guarantee accountability. However, collecting data—especially data disaggregated by age, gender, ethnicity, and social and economic status—can be hugely beneficial. First, it allows countries to monitor themselves, to see whether the resources they commit really do have the effect they intend, especially for the most disadvantaged groups. Second, it makes the health policy of a country visible to the international community, and, provided that the country cares about its reputation, may provide an incentive to change. Yet we have to be aware that, on the other hand, hitting targets can become an end in itself and undermine the quality it is intended to promote. There may be no easy way out of this dilemma, but at least under current circumstances monitoring countries

against a wide range of targets probably has many more advantages than disadvantages.

**THE HUMAN RIGHT TO HEALTH IN PRACTICE**

We have, so far in this chapter, looked primarily at conceptual and philosophical questions. A quite different argument focuses on what we might call the political sociology of human rights, and in particular rights of advocacy and empowerment. In recent decades, a good number of human rights organizations have come into being to protect the human rights of oppressed peoples. These include, of course, Amnesty International, now more than fifty years old, Human Rights Watch, and many others. Such organizations campaign, lobby, and take legal action on behalf of those whose rights have been violated. This, it is said, while often highly beneficial and effective, nevertheless has the effect of further disempowering disadvantaged people. Human rights activists will tend to be relatively privileged people from the developed world acting on behalf of others, who will be passive beneficiaries of their energetic activities.

Once more we must, I believe, admit that this is a real danger, and encourage NGOs to review their own role in possibly compounding the disempowerment of disadvantaged people. For this reason, some of the most encouraging developments in human rights activism are precisely those that facilitate disadvantaged people’s self-advocacy, as we will explore later. The role for NGOs is to provide training and support, and to help form a radicalized and empowered community, able to fight its own battles in the future. It is therefore highly important for NGOs to focus not only on the goals of their campaigns, but
the means by which those goals are obtained. It should be part of the mission statement of every development NGO that its ultimate aim is to make itself redundant, or at least regularly to review the reasons for its existence.

A more recent, and very urgent, criticism is that the practice of advocacy for the human right to health has done more harm than good. This argument has been made by William Easterly,32 who is a very perceptive commentator on development issues and must be taken seriously.33 Easterly’s specific argument is that pressing for the right to health leads to distorted health priority-setting, diverting resources, effectively, to those who shout the loudest and are most effective in their advocacy, to the detriment of general health promotion. Easterly claims that pursuing the right to health leads to resources being spent in an inefficient manner, and that societies would be better off with cost-effective health-maximizing strategies.

There are at least two issues here. One is that a human rights culture favors those who have access, via lawyers, to the courts, namely the wealthy and well-connected.34 The second is that human rights advocacy encourages interventions with a narrow focus, be it HIV/AIDS, malaria, maternal care or whatever. This, in turn, leads to what are called “vertical programs” that mobilize resources around a single condition, which can have the effect of severely weakening health systems.

Easterly is certainly right that single-issue advocacy can be damaging to health systems. For example, it has been argued that in sub-Saharan Africa, as ever more money is spent on HIV/AIDS programs, the proportion of attended births goes down.35 The reason for this is that health workers are drawn to the better-funded campaign areas and away from general practice, which is left depleted of skilled personnel. This is a very serious problem which we will explore in detail in chapter 4.

However, it is unclear why Easterly should think that the problem of vertical programs is somehow intimately connected with the right to health. Advocacy for the human right to health is as likely to be addressed to health-system strengthening, including public health, as to single-issue projects, and, indeed, as the problem is becoming better known advocacy is increasingly focused on systems rather than particular diseases.

With respect to his other claim, that a human rights culture in effect diverts resources to the already wealthy and well-connected, the position is mixed. In chapter 3, we will see examples of jurisdictions, most notably South Africa, where judges have explicitly argued that courts of law are not the right fora for health resource allocation decisions to take place. In these jurisdictions there is no evidence that the human right to health has led to judicial decisions overturning cost-effective state decisions about health services. Although court action is the ultimate sanction for human rights abuse, in reality in many jurisdictions it is rare, while, as we saw in chapter 2, policies of “naming and shaming” are more common and effective,36 and may be pursued with respect to the poor and vulnerable. Consider, for example, the study of “excess deaths” in the aftermath of the invasion of Iraq, which showed that the number of civilian deaths in Iraq after the invasion was much higher than normal, not only from death by violence, which suggests that the invasion led to a general increase in health problems and a reduced capacity to deal with them. Although not explicitly part of a human rights agenda, it is highly appropriate for that purpose.37

However, not all legal cultures act in the same way. In Latin America there have been very many—perhaps even tens of thousands—cases in which human right to health arguments have led to court orders for treatment, and in the great majority of examples for access to expensive medicines at public expense.
For example, it is claimed that in Brazil there is now an “epidemic of litigation” under the heading of the right to life and right to health, for access to therapies for not only HIV/AIDS but also for diabetes, Alzheimer’s, and multiple sclerosis, among other conditions. The evidence appears to be that the successful litigants tend to come from socially and economically more advantaged groups. How damaging this is overall is unclear, but it is a reasonable conjecture that it is damaging health equity and cost-effective planning. The lesson from Easterly’s challenge is important. It should never complacently be assumed that attempts to do good can do no harm. This is as true for rights advocacy as it is for anything else.

The purpose of this chapter has been to examine two different ways in which the idea of the human right to health has come under pressure. One challenge worries about its moral foundations, the other its practical application and consequences. In the process of exploring the meaning, foundations and implications of the human right to health, we have also clarified its content, in the form of General Comment 14. At the same time we have acknowledged that not everyone will accept that the criticisms have been adequately answered. But it is now time to turn to the real world of health and human rights, to the individual and social manifestation of illness and disease, and how thinking of health in terms of a human right can help facilitate action to prevent, or at least reduce, suffering. We will do this by means of a detailed case study of a vital area of global health, the HIV/AIDS epidemic. We will examine how human right to health theory and action developed alongside the HIV/AIDS epidemic, first in the developed world, but now as part of a global response.