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The promise of human rights for global health: A programmed deception? A commentary on Schrecker, Chapman, Labonté and De Vogli (2010) "Advancing health equity in the global market place: How human rights can help"

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Introduction

There have been an increasing number of initiatives and efforts to use the language, institutions and procedures of human rights in the field of global health over the last 20 years (Gable, 2007). HIV/AIDS was one of the first global health issues where human rights were deployed, generally to protect those with HIV/AIDS from stigma and discrimination. The creation of a Human Rights Office by Jonathan Mann within the WHO's Global Program on AIDS is a typical illustration of such efforts (Fee & Parry, 2008). Global health activists have also used human rights in relation to access to medicines. Indeed, from the celebrated South African HIV/AIDS medicines access campaign led by large, international NGOs like Oxfam and Médecins Sans Frontières, to efforts by Brazilian patient groups to obtain free drug treatment for rare genetic diseases, all have explicitly appealed to human rights norms found in international treaties and national constitutions (Olesen, 2006; Petryna, 2009). More recently, public health advocates have sought to use human rights in the field of tobacco control. They have tried to exploit the monitoring and complaint mechanisms offered by UN human rights conventions to force the adoption of more stringent anti-smoking policies (Reubi, in press).

Schrecker, Chapman, Labonté, and de Vogli's (2010) *Social Science & Medicine* article 'Advancing Equity on the Global Market Place: How Human Rights Can Help' contributes to these recent developments. Their article is yet another invitation to use human rights in the field of global health. Schrecker et al. (2010, p.1521) start their paper by contending that 'market fundamentalism' – a mentality of rule shaped by neo-liberalism and centered on the market that has become dominant worldwide – has not only led to rising poverty and economic insecurity but has also been detrimental to health, as measured by life expectancy at birth. To counter market fundamentalism and resist further declines in life expectancy especially among the poor, they suggest that we turn to the norms, institutions and procedures that make up the international human rights framework. More particularly, they suggest that we use the right to health found in article 12 of the 1966 *UN International Convention on Economic, Social and Cultural Rights* (ICESCR) and further spelled out by both the UN Committee on Economic, Social and Cultural Rights' (CESCR, 2000) and the UN Special Rapporteur on the Right to Health (SRRH). They also suggest using specific 'mechanisms of accountability' in order to effectively realize article 12 ICESCR (Schrecker et al., 2010). In particular, they mention litigation procedures in national courts of law, the CESCR's reviewing process of periodic state reports, and the SRRH's annual reports and state missions.

Schrecker et al. are not alone in thinking that the international human rights framework can offer a solid bulwark against global market forces and their detrimental impact on health. Indeed, plenty of hope has been associated with this framework of late and the idea expressed by Schrecker et al. can be found, implicitly at

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least, in the work of several other scholars. For example, the first SRRH, Hunt (2004), has argued that international human rights forbid the adoption of trade liberalization policies that have deleterious health effects. Similarly, Forman (2008) has argued that human rights are an effective tool to contest the World Trade Organization's trade regime and secure affordable access to medicines. However, unlike Schrecker et al. and scholars like Hunt and Forman, I remain skeptical about the international human rights framework's capacity to stop and reverse the decline in life expectancy brought about by neo-liberal policies. To start with, it is somewhat odd for health activists to look to the international human rights framework as a solution, when it appears to have achieved so little tangible results in other contexts. Whether it be the campaigns of terror and torture carried out by military regimes in Latin America, or the genocides in Rwanda or the former Yugoslavia, the failure of the human rights regime to protect individuals from the most serious of harms is depressingly clear (Hathaway, 2002). Moreover, the international human rights framework is also replete with problems of a more fundamental nature – its Western cultural bias; its articulation around the nation-state – that have never really been resolved (Kennedy, 2002).

The international human rights framework's poor record at protecting people and its numerous inherent problems should, I believe, make us cautious about embracing it as the solution to the ill effects of market fundamentalism. At the very least, I suggest that we should thoroughly examine the different problems that such a solution would entail – something Schrecker et al. fail to do – before we pin all our hopes on this framework. The purpose of the present commentary is not, of course, to carry out such a thorough examination. It can, however, be a first step towards thinking about the potential problems inherent to a human rights approach to global health. To that effect, I discuss below my three main concerns in relation to the use of human rights to improve health. First, following an argument made by British philosopher Onora O'Neill (2005), I ask whether it would not be more efficient to use the energy, time and money spent on setting up and running a human rights framework on doctors, drugs and hospitals. Second, building on the anthropological research recently carried out by Adriana Petryna (2009) in Brazil, I question whether litigation in national courts – identified by Schrecker et al. (2010) as a key mechanism to realize the right to health – is increasing rather than reducing health inequalities. Third, I inquire whether the international human rights framework which identifies states rather transnational corporations as having the obligation to respect and promote human rights is really the best suited to tackle global market forces. The purpose of this discussion is not to come up with a definite answer but to encourage us to carefully assess the promise of human rights as an answer to global health problems before we commit to them.

Doctors and drugs rather than lawyers and legislation?

As mentioned, my first concern is whether it would not be wiser to invest the energy, time and money spent on a human rights framework in doctors, drugs and hospitals – an argument made by Onora O'Neill in her thought-provoking essay *The Dark Side of Human Rights* (2005; cf. also Kennedy, 2002). Human rights are not just written lists of well-meaning moral principles. Indeed, as Schrecker et al. (2010, p.1522) themselves admit, human rights are also 'mechanisms of accountability:' procedures through which these lists of principles are (partly) transformed into reality. O'Neill (2005, p. 436) uses another, more contentious expression for Schrecker et al.'s mechanisms of accountability: 'a system of control.' Such a system, she explains, is a complex assemblage of:

> '[1] procedures that bristle with duties to register, duties to obtain permission, duties to consult, rights to appeal as well as proliferating requirements to record, to disclose and to report; … [2] copious regulation, relentless guidance, prolix codes of good practice and highly intrusive forms of accountability; … and [3] state agencies … inspectors and regulators' (ibid., p.436–437).

Whatever the expressions and descriptions we use, the critical point is that human rights are much more than written lists of moral principles. First, human rights are the vast legal knowledge found in international treaties, court judgments, official reports, legal textbooks, codes of good practice and how-to manuals. This knowledge tells you not only that we all have a right to health but also what this right entails, against whom you can claim it, what procedures you should follow to do so, who can assess your claim and what types of redress you are entitled to. Second, human rights are the various institutions that generate legal knowledge, monitor the realization of human rights and assess whether they have been violated: courts of law; *ad hoc* bodies like the SRRH; human rights ombudsmen; official committees like the CESCR; university law departments; and special administrative subdivisions like the WHO Health and Human Rights Unit. Third, human rights are legal experts – professors, solicitors, judges, lawyers, administrators, etc. – that run the institutions listed above. Fourth and finally, human rights are procedures through which legal knowledge is operationalized, such as: complaint procedures to courts of law to claim redress for the violation of one's right to health; and regular reporting procedures to monitor the realization of the right to health by particular states.

As O'Neill (2005, p.437) has argued, this assemblage of knowledge, institutions, experts and procedures generate 'heavy human and financial costs.' The human costs she refers to are the time and energy spent by people complying with the requirements of a human rights framework: obtaining permissions, consulting third parties, recording, disclosing, reporting and complying with the demands of the inspectors and regulators. This, O'Neill (2005, p.437) suggests, will lead to 'increasing wariness and weariness, skepticism and resentment and ultimately less active engagement.' Besides these human costs, there are also financial costs. These will include things like outlays to build courts of laws and law departments, budgets to run special commissions and administrative units and expenses to educate and remunerate experts. Given that resources are ultimately limited, I suggest that it would be important to examine whether the energy, time and money associated with setting up and managing of a human rights system should not rather be invested in doctors, drugs, hospitals, research facilities, medical technologies and the like which might have more direct and tangible health benefits. Such an examination might well conclude that, if a human rights framework is worthwhile at all, it should be a much more stripped down and less cost-intensive version than the one we currently have.

Does the judicialization of the right to health necessarily bring more health equity?

My second concern is whether the human rights framework effectively brings about increased health equity. More specifically, building on the anthropological research recently carried out by Adriana Petryna and her colleagues in Brazil, I question whether litigation in national courts is increasing rather than reducing health inequalities (Biehl, Petryna, Gertner, & Picon, 2009; Petryna, 2009; cf. also Gloppen, 2008). Like many other South American nations, Brazil incorporated the right to health in its national constitution in the late 1980s. It guaranteed all Brazilians universal

access to health care and medicines. This was realized by extending health care coverage, including pharmaceutical assistance, to all citizens through a national health system. From the early 1990s, litigation became an increasingly popular method for patients in Brazil to access drugs that were not yet offered through pharmaceutical assistance programmes. As a consequence, legal suits filed by patients against the state have skyrocketed across the country, especially during the last decade.

As Petryna (2009, chapter 4) shows, up to 1996, most legal cases related to anti-retroviral drugs and were filed by public prosecutors in the name of the poor. This changed when anti-retroviral drugs were added to the list of medicines offered by pharmaceutical assistance programs in 1996. Since then, an increasing number of claims have focused on new high-cost drugs for rare diseases. Many of these were filed by associations of patients and their families. An example is the Souza family. After having their son Pedro diagnosed with Gaucher disease, they got together with other families whose members suffered from the same rare hereditary disorder and sued the state for free access to a new expensive drug that treated the disorder. Soon afterwards, they were granted the right to treatment by a judge and the drug was included on the national disease programme. Petryna further shows how, more recently, North American drug companies have also sought to take advantage of the judicialization of the right to health in Brazil. To do so, they come to Brazil to conduct clinical trials to test new drugs for rare diseases that they have been developing. The trials allow the companies to recruit interested patients and show them the efficacy of the drug in treating their disorder. When the trial finishes, after 2 or 3 years, the patients are taken off the drugs and encouraged to form patient organizations and use the language of rights to demand that the state provides them with the drugs from then on.

As Petryna and her colleagues argue, 'this judicialization of the right to health … has the potential to widen inequalities in healthcare delivery' (Biehl et al., 2009, p.2182–2183). The legal suits, many of which have been successful, have led the costs associated with pharmaceutical assistance to spiral ever higher. It is not only that there is an increasing number of drugs to provide to Brazilian patients, but that many of these new drugs are exceptionally high-cost. So, for example, the drug to treat Pedro Souza's Gaucher disease costs $200,000 per year per patient. As Brazil's budget for pharmaceutical assistance is not unlimited, this extra money spent on a new, high-costs drugs has meant that there is less money available to pay for standard treatments. This is hardly an improvement in terms of health equity – Schrecker et al.'s declared aim. Indeed, those that take advantage of the judicialization of the right to health seems to be North American pharmaceutical companies and the Brazilian middle-classes who, like the Souzas, can organize themselves, raise funds and file lawsuits. At the same time, there are fewer standard drug treatments available to the poor in Brazil. As Pedro Souza's mother herself admits, 'there is this selfishness' associated with the judicialization to the right to health: 'you have to care for your child and family, and you know that others do not have it' (cited in Petryna, 2009, p.177). Given these findings, it would, as Gloppen (2008) has argued, be worthwhile to examine closely the impact of human rights litigation for health equity.

Are human rights adapted to tackle global market forces?

My third concern is whether an international human rights framework that does not recognize transnational corporations (TNCs) as obligation holders is suited to tackle the forces that make up today's global market. The international human rights framework is articulated around states rather than TNCs. States are deemed to be both the principle violators and the principle protectors of human rights norms. As Harvard law professor Kennedy (2002, p.113) explains:

> 'Although the human rights vocabulary expresses relentless suspicion of the state … human rights also place the state at the centre of the emancipatory promise … rights are enforced, granted, recognized, implemented, their violations remedied, by the state.'

The centrality of states in the human rights system is marked by the fact that only they can ratify international human rights conventions and, thereby, sign up to respect and protect the principles contained therein (OHCHR & WHO, 2008; O'Neill, 2005). Thus, only states can ratify the ICESCR and, thereby, commit to realize the right to health contained in article 12 of the convention. In contrast, non-state actors – transnational corporations, civil society groups, religious organizations, professional bodies, etc. – are not allowed to become party to international human rights conventions. They are not deemed to be holders of human rights obligations (OHCHR & WHO, 2008; O'Neill, 2005).

This centrality of states reflects their extraordinary dominance in the post-war and cold war periods when the international human rights framework was first established. As states have been deemed to become weaker post-1989, there have been attempts to adapt the framework and oblige powerful non-state actors like TNCs to also respect human rights. These attempts have led, for example, to the creation, in 2000, of the *UN Global Compact* – a series of ten human rights principles which TNCs can voluntarily sign up to and pledge to respect. These attempts have also led to the nomination, in 2005, of a UN Special Representative whose mandate has been to look into the relation between human rights and private business.

However, these attempts notwithstanding, states remain the primary holders of the obligation to respect human rights. As the OHCHR and WHO (2008, p.30) explain in their *Fact Sheet on the Right to Health*: 'states are, ultimately, accountable for any violation of human rights.' Of course, this has meant that the human rights framework has remained pretty much toothless to confront the increasing influence of TNCs. This can be illustrated by Paul Hunt's powerlessness when trying to have the private sector partake in the drafting of and adopt his *Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines*. Not one among the many pharmaceutical companies that he contacted signed up to his guidelines and only two felt an obligation to come and speak with him (Khosla & Hunt, 2008). They knew that, while he had the authority, as a UN Special Rapporteur, to conduct missions in countries and hold meetings with governments, he did not have the power to force TNCs to speak with him or accept any guidelines from him. It is therefore essential to examine whether the fact that TNCs cannot be held accountable within the international human rights system seriously hampers its use as a bulwark against global market forces.

Conclusion

Schrecker et al. have argued that one should use the international human rights framework in order to counteract the detrimental health impact of market fundamentalism worldwide. They are not alone in thinking along these lines. An increasing number of scholars seem to share their hope that human rights can protect us from neo-liberal rule's ill effects. I, however, remain skeptical. Indeed, given this framework's poor record at protecting people and the important problems that have plagued it over the years, I am worried that the promise of human rights will necessarily end up in deception. I would argue that we should, at the very least, thoroughly examine the possible problems that a human rights approach to global health might entail before we decide to embrace it.

The purpose of the present commentary has been to initiate such an examination. To that effect, I have outlined the three main concerns I have in relation to the use of human rights to improve health. First, building on Onora O'Neill's work, I asked whether it would not be wiser to spend our time, energy and money on doctors and drugs instead of on human rights lawyers and legislation. Second, drawing on Adriana Petryna's research, I queried whether the judicialization of the right to health is not increasing rather than decreasing health inequalities. Third, I wondered whether an international human rights framework that cannot hold TNCs accountable is really our best option to thwart the detrimental impact of the global market place. In doing so, I have not sought to provide definite answers but only to encourage us to start reflecting on the possible problems that are inherent to a human rights approach to health. Indeed, I think it is vital that we critically assess the promises of human rights before we further promote them as the solution to what Schrecker et al. term market fundamentalism.

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