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A Defence of the Human Right to Health

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Abstract

Opponents of the right to health (RtH), such as William Easterly, argue it is incompatible with resource constraints, or leads to problematic outcomes. However, Easterly's concerns are not inherent to the RtH, if it is interpreted correctly. Not only is the RtH applicable in resource-constrained contexts, it is also an essential guiding principle for policy. Fair priority-setting can alleviate Easterly's concerns. Moreover, the RtH must not be discarded so quickly, as it also plays a very important role in fighting discrimination in healthcare, empowering in particular women and people of colour to demand equal standards of care for all.

Keywords: Human rights; Right to health; Priority-setting; Discrimination

The question of the existence (and viability) of a fundamental right to health is a contentious one. In an influential piece published in the Financial Times and titled "Human rights are the wrong basis for healthcare", William Easterly argues that invoking a "right to health" leads to a problematic use of resources, especially in the context of foreign aid. (Easterly 2009: 1) Before delving into his argument, it is useful to define what is meant by the "right to health" (RtH). The RtH first appeared in the preamble of the 1946 Constitution of the WHO, itself an agency of the UN. It is formulated as follows: "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." (WHO 1946: 1) In addition to international human rights treaties, the RtH is also found in a number of national constitutions. It therefore has legal grounding, both at the international and national level: in Brazil, for instance, the constitutional RtH introduced in 1988 has led to thousands of successful lawsuits claiming health services from the government. (Ferraz 2011: 67)

Easterly argues that the introduction of a human RtH in the 1940s has done more harm than good, for two main reasons. The first claim is that the RtH as it is formulated in the WHO Constitution is inherently problematic, as it is impossible for all humans to simultaneously attain the "highest attainable standard of health" (WHO 1946: 1), due to resource constraints which inevitably restrict the application of the RtH (Easterly 2009: 1). The second claim is a consequentialist argument against the RtH: he argues that RtH discourse skews resources towards the causes that have the most powerful advocates, and away from causes which

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would have maximised health benefits for the same cost. Choosing the latter is presented as the morally superior approach to healthcare.

In this paper, I respond to Easterly by attempting to demonstrate that the RtH, interpreted and applied correctly, is fundamental to good healthcare practices and to a fair allocation of resources at the local and the global level. Firstly, I argue that the claim that the RtH ignores resource constraints is dependent on a particular interpretation which is more limiting than it needs to be. I propose an alternative interpretation of the RtH as the right to a fair and accountable priority-setting system, which takes resource constraints into account. "Priority-setting", from the perspective of health systems, refers to the process of assessing different claims on resources based on a set of pre-defined principles, and releasing these resources accordingly. Secondly, I argue that Easterly's concerns are not inherent to the RtH – rather, they are attributable to flawed priority-setting systems. To support this, I propose changes to these systems which would alleviate Easterly's concerns without resorting to his proposal of exclusively maximising total health benefits for a given cost (Easterly 2009: 2), which is a potentially damaging approach unless extra weight is given to benefits for the worst-off. Finally, I argue that the RtH should not be discarded: interpreted correctly, it is fundamental to good healthcare practices, particularly in safeguarding freedom from discrimination, which is a real issue for healthcare today, both at the local and global level.

Easterly's definition of the RtH is unclear, and his argument is dependent on a particular version of it, which would conflict with resource constraints. He states that RtH advocacy in the context of foreign aid is a positive endeavour only as long as it does not divert resources away from other, more pressing causes (Easterly 2009: 1). The case study he cites as illustration is that of aid-financed AIDS treatment in Africa, which he argues swallowed resources which could have produced a higher health benefit had they been used on big killers of the poor such as TB and malaria. However, the evidence he presents is not sufficient to support his argument. For instance, it could be that following the AIDS advocacy campaign, foreign aid increased significantly in support of this cause, while aid to other causes remained constant: that TB and malaria would have been a better use of resources does not imply that the AIDS campaign *took away* resources from those causes. Moreover, causes such as AIDS still need to be addressed (Wolff 2012: 234), so there is a moral dilemma here when it comes to allocating resources, regardless of the RtH.

Easterly's argument is that the RtH disturbs the priority-setting process by introducing a moral obligation to respond to health claims, leading to the causes with the most vocal and well-connected advocates absorbing resources which could have been better used elsewhere. However, this entails a particular interpretation of the RtH, which is more limiting than it needs to be and prevents it from fulfilling one of its most important roles: that of being a guide for policy, and in particular for a fair priority-setting system. At the end of his piece, Easterly states that in rich countries, the RtH is "a claim on funds that has no natural limit, since any of us could get healthier with more care" (Easterly 2009: 2). This is a possible interpretation of the RtH which does have its examples in the real world: for example, in the case of health litigation, for example in Brazil (Ferraz 2011), such an interpretation can be used to argue that cost-effectiveness is not a valid reason to refuse treatment. However, in practice, health systems must attempt to balance the RtH with a fair allocation of resources. With resource constraints, there is no right to health in the sense that there is no right to treatment. However, there is a human right to equal claim on health resources, and to a fair priority-setting process. This priority-setting process must be transparent and accountable, with each citizen able to understand how claims are assessed and to make use of democratic institutions if they wish to question the underlying allocative principles. The NHS's priority-setting principles, for instance, are available online and clearly defined, although their formulation often leaves space for debate over the details (NHS

Commissioning Board 2013). Thus, the RtH does not inevitably conflict with resource constraints, as it can be understood as the right to a fair and transparent priority-setting system. In fact, the RtH provides a reason that such prioritisation needs to occur in the first place (Rumbold et al. 2017: 713), as it safeguards equal access to resources through principles which apply to all individuals.

Easterly's concerns about allocative decisions are not inherent to the RtH, but to flaws in the priority-setting process. Even if we accept Easterly's claim that AIDS advocacy took away resources from TB and malaria, it is unclear why this is specifically an issue for the RtH. Indeed, the concentration of foreign aid on vertical health programmes (such as the AIDS campaign) rather than horizontal programmes seeking to generally strengthen health systems in poor countries is an issue regardless of RtH advocacy. In fact, the RtH is increasingly used to advocate for horizontal measures (Wolff 2012: 234). That some have invoked the right to health as part of flawed reasoning does not mean that the right to health cannot produce good policy outcomes at all, in the same way that some invoking freedom of speech to spur violence does not mean we should do away with freedom of speech entirely, or that it cannot be a guiding principle in policy. All it means is we should ensure that we have systems in place to prevent rights being invoked wrongly. This entails that the right to health cannot stand on its own: just like freedom of speech must be balanced out with respect, the right to health must take into account resource constraints and put in place systems to ensure resources are allocated fairly and transparently. Easterly implies that a fair priority-setting system is one which would simply maximise total health benefit for a given cost (Easterly 2009: 2). This should be *one* of the aims of a fair and effective priority-setting system, but it should not be the only aim: the blind utilitarian approach fails to consider that health benefits to the worst-off may have a higher marginal value from the point of view of justice. A priority-setting system which seeks to maximise health benefits for a given cost but gives extra weight to health benefits to the worst-off would alleviate Easterly's concerns. As long as foreign aid is channelled through such a system, resources will be allocated to the "neediest" (Easterly 2009: 2).

My final criticism of Easterly concerns an aspect of the RtH that he does not address in the article, and which I consider to be one of the most important arguments for using human rights as a basis for healthcare. Easterly devotes his argument to one side of the RtH as it is formulated by the WHO, focusing on the part which states the "highest attainable level of health" for all, rather than what follows: equal concern for all individuals "without distinction of race, religion, political belief, economic or social condition" (WHO 1946). This anti-discrimination principle contained in the RtH has two important applications. At the global level, it provides a reason for foreign aid, which increases equality of access to health resources across nations. At the local level, it responds to the pervasive issue of discrimination in healthcare. This discrimination can be overt, but most often it is due to implicit bias on the part of healthcare providers. For example, a study shows that a patient's gender influences a doctor's estimation of their pain, leading to significant underestimation of women's pain, and to women being more likely to be prescribed psychotherapy over analgesics than men (Zhang et al. 2021). This gender bias can have devastating consequences on women's health. For instance, it may explain the fact that women suffering from endometriosis, a disease which causes extremely painful periods, must wait on average 8 to 12 years before they are diagnosed with the disease (Pugsley and Ballard 2007). This is especially shocking considering it is estimated that 10% of women suffer from endometriosis. Evidence of a racial bias in pain assessment is also well documented. (Hoffman et al. 2016) The RtH can provide a legal tool for patients who have faced health-related stigma to report it. It fights the normalisation of such issues. A woman suffering from endometriosis, and even more so a woman of colour who may compound two biases, should not have to have her pain dismissed by fifteen doctors before it is finally taken seriously by

another, because she has a right to health. The issue of discrimination at the local level is not explored by Easterly, but it is a crucial use of the right to health which should be promoted so that those affected by health-related stigma can, firstly, become conscious of the problem, and secondly, know they have grounds to fight back. In that sense, human rights are absolutely the right basis for healthcare, as they empower individuals to exercise their right to equal standards of care.

In conclusion, I have argued that although Easterly's concerns may be justified, they are not inherent to the RtH, as long as the RtH is interpreted as the right to a fair priority-setting process which seeks to maximise total health benefits while taking resource constraints into account and placing extra weight on benefits to the worst-off. Interpreted in this way, not only is the RtH applicable in resource-constrained contexts, it also a useful guiding principle for allocative policy. Fair priority-setting, even at the global level in the case of foreign aid, can alleviate Easterly's concerns. Moreover, I depart from the scope of Easterly's argument to argue that the RtH must not be discarded so quickly, as it also has a very important role to play in fighting discrimination in healthcare at the local level, empowering in particular women and people of colour to demand equal standards of care for all.

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