Adapting to International Health and Human Rights Standards

By Lesley A. Jacobs

"Human rights can and should be declared universal, but the risk of having one's rights violated is not universal."[1]

Although health as a human right was acknowledged by the international human rights community more than fifty years ago in the 1948 United Nations Declaration of Human Rights and its significance was reiterated in the 1966 International Covenant on Economic, Social and Cultural Rights, still last year the distinguished medical anthropologist and human rights physician Paul Farmer in his 2005 book *Pathologies of Power: Health, Human Rights, and the New War on the Poor* felt compelled to write, "The field of health and human rights, most would agree, is in its infancy. Attempting to define a new field is necessarily a treacherous enterprise. Sometimes we appear to step on the toes of those have long been at work when we mean instead to stand on their shoulders."[2] The arguments of this paper risk me stepping on toes, although the contribution it proposes to make to the field of health and human rights is a very modest one.

Before turning to those arguments, it is important to identify what I believe to be the three important strands of work on health and human rights that have marked the field in the past fifteen years. The first strand revolves around skepticism about the separation of civil and political rights, on the one hand, and social and economic rights, on the other hand. Of course, among political philosophers, such skepticism has deep roots and there exist numerous examples of philosophical arguments designed to show that such a separation is nonsensical.[3] In the field of health and human rights, however, this skepticism did not stem from philosophical roots. Rather, it has its origins in the experiences of physicians and human rights activists responding to the AIDS epidemic in the late 1980s and early 1990s. Perhaps the best known proponent of such a view was Jonathan Mann, who served as the first head of the World Health Organization's Global Program on AIDS. In the course of that role, Mann came to believe that the protection of

1 Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (Berkeley CA: University of California Press, 2005), p. 231.
2 Farmer, *Pathologies of Power,* p. 220.
3 See e.g. my book *Rights and Deprivation* (Oxford UK: Oxford University Press, 1993).

civil and political rights was not only compatible with the fight against AIDS but central to that struggle. In effect, what Mann argued was that the global AIDS epidemic had its origins not just in the contagion of a newly emerging infectious disease but also social vulnerability. His point is that discrimination and stigma are a fundamental part of the problem, and that for this reason AIDS is a also a traditional human rights problem.[4] The impact of this reasoning is most evident in the United Nation's Millenium Goals.

The second strand revolves around the increasing recognition of the so-called social determinants of health in the late 1990s. At issue here is the view of health, most commonly identified with Richard Wilkinson and Michael Marmot, as not simply about individual behavior or exposure to risk, but how the economically and socially structured way of life of a population shapes its health.[5] The point is that the ambit of health concerns extends not just to medical care and public health measures but also to social issues such as poverty, housing, social exclusion, and the environment. The upshot of this research is that health as a human right is linked seamlessly to other human rights such as the right to an education, income security, or housing.

The third strand of important developments in the field of health and human rights is even more recent than these other two. Recently, in *The New York Review of Books*, Tony Judt predicted a resurrection of Marxism on the grounds that despite all of its failures, "no one else seems to have anything very convincing to offer by way of a strategy for rectifying the inequities of modern capitalism, the field is once again left to those with the tidiest story to tell and the angriest prescription to offer."[6] In my view, Judt here overlooks the profound influence most notably of Paul Farmer (but also others) who have invoked the framework of health and human rights to critique such inequities, a critique that builds on the comprehensive view of health explicit in the other two strands in the field of health and human rights I have just noted. Flowing from that comprehensive view is the claim that most of the inequities and inequalities of neoliberalism and global capitalism are assaults on the health of populations. By putting health and healing at the center of that critique, writes Farmer, "we tap into something truly universal – concern for the sick."[7]

The purpose of this paper is to re-examine in the light to these important developments in the field of health and human rights the well known statement in article 2 of the International Covenant on Economic, Social and Cultural Rights, which allows that social rights including the

4 Jonathan Mann, "AIDS and Human Rights: Where Do We Go from Here?," *Health and Human Rights 3*, pp. 143-49.

5 Michael Marmot and Richard Wilkinson, editors, *Social Determinants of Health* (Oxford UK: Oxford University Press, 1999). See also Richard Wilkinson, *Unhealthy Societies* (London: Routledge 1996).

6 Tony Judt, "Goodbye to All That?", *The New York Review of Books LIII, No. 14*, 21 September 2006 (pp. 88-92), p. 92.

7 Farmer, *Pathologies of Power*, p. 238. See also Paul Farmer, *Infections and Inequalities, Paperback Edition* (Berkeley CA: University of California Press, 2001)

right to the highest attainable standard of health can be fulfilled through progressive realization. This article is a reflection of the belief common in the international human rights community that the fulfillment of health as a human right, like other social and economic rights, is contingent on the particular socio-economic circumstances that exist in the country where the right holder lives. The point is that unlike say the right not to be tortured there is not a universal and uniform basis for determining what a right to health might require of others, in particular, member states of the United Nations. This paper sets out to explain how the right to health can be a human right whilst allowing that what it requires can vary from country to country. The discussion links two distinct aspects of my work on the right to health. One aspect, which I have developed in a number of contexts recently, is the theoretical one that from a health care resource perspective, the right to health entails an in-kind benefit, which cannot be exchanged for something of equivalent market value. The other aspect involves what myself and several collaborators have been describing as the selective adaptation of international laws and norms by local communities. The paper includes references to my research on health care systems in Canada, the United States, and China.

The Two Components of The Right to Health: Freedoms and Entitlements

The right to health has been interpreted by the United Nations as involving two distinct components, on the one hand, freedoms, and on the other hand, entitlements.[8] The essential freedoms at stake are the right to make one's own decisions about health and body including consensual medical treatment and the right to be free from interference and discrimination. Entitlements are held against an individual's state or government. These entitlements do not include good health because that cannot be ensured by a state. Thus, observes the UN Economic and Social Committee , "the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health."[9]

Now, in my view, what is important here is that these entitlements are to in-kind benefits.[10] Redistribution by states is ordinarily pursued through what economists and public policy analysts call transfers. Redistributive transfers can be either in-kind or cash. Benefits, as I shall use the term, denote particular in-kind or cash transfers. In-kind redistributive transfers involve the transfer of specific goods in some form or another. The central point is that the

8 UN Economic and Social Council, *General Comment No. 14: Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights* (11 August 2000), paragraph 8.

9 Ibid, paragraph 9.

10 See e.g. my chapter "Justice in Health Care' in Justice Burley, editor, *Dworkin and His Critics, With Replies by Dworkin* (Oxford UK: Blackwell 2004) as well as chapter seven of my book (New York: Cambridge University Press, 2004).

entitlements at issue in a right to health care involve the use of in-kind transfers and do not allow individuals to trade-off health care benefits for cash or other goods. Typical in-kind benefits other than health care include education, housing, and food stamps. These differ from benefits in cash. Typical cash benefits are child benefit, tax credits, social assistance, unemployment insurance, disability insurance, and social security pensions. This type of benefit leaves it up to the recipient what to spend the cash on.

An example can illustrate the normative bite of why I am noting this point. Consider the case of someone who has, through bad luck, contacted a serious illness. An operation can be performed that will treat this illness. Suppose that the patient is a citizen in a state that operates a health care scheme that guarantees universal access grounded on a right to health and that the operation in question will be covered under this scheme. But the ill person is peculiar because he says that he would rather have the money spent on something else, some good he values more than health care. (It is easy to imagine, at present, an AIDS patient saying precisely this sort of thing; he would prefer to have certain resources in cash so that he could use it to do things in life he had always wanted to do instead of spending it on expensive medical equipment designed to prolong his life.) Why shouldn't the health care scheme compensate him in this form rather than by paying for the operation? The simple answer is that the right to health amounts only to an entitlement to the health care, not the cash equivalent.

The point I am making is significant in two respects. First of all, it undermines a common argument that the right to health is fulfilled if an individual could have at some point afforded to buy health insurance but chose not to…

Second, this emphasis on in-kind entitlements captures the idea that the right to health involves a concern specifically with the redistributive benefits to the sick…

In What Sense Are International Obligations Flexible?

The difficulty in assessing any county's performance in the realm of health stem from the broader problem of if and when the demands of the human right to health on developing countries such as China should be regarded as flexible. The international human rights community seems to be of two minds about this problem. In for example the 1993 Vienna Declaration and Programme of Action, the UN claimed, "The international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of States, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms."[11] The underlying point in theory is that all international human rights

11 Vienna Declaration and Programme of Action (June 25 1993), available at www.unhchr.ch/huridocda/huridoca.nsf/(Symbol)/A.CONF.157.23.En?OpenDocument - 87k –.

are held to be universal and designed to be culturally neutral.[12] Yet, as is well known, Article 2 of the ICESCR allows for the "progressive realization" of all social rights including the right to health. The underlying principle is designed to acknowledge that developing countries often lack the resources at this point in time to realize fully social and economic rights such as the right to adequate health care and hence seems to suggest considerable flexibility in terms of the demands of those rights.

The progressive realization provision of the ICESCR allows for some flexibility in its demands on member states. Part of what is worrisome about flexibility with regard to what constitutes compliance with its international obligations in the realm of health and human rights in say the case of China is that any substantive sense of non-compliance risks being lost. Should this occur and non-compliance is reduced largely to arbitrary or discriminatory conduct, the specific content of the international obligations at issue is neglected, and it is here that some of the grossest violations of human rights to health occur.[13] "If, for example," Leonard Rubenstein writes, "a state violates its obligations to implement programs for maternal health, allowing women to suffer and die, it should not matter that the decision was not arbitrary."[14] In its 2000 general comments about how to implement the ICESCR, the UN Economic and Social Council insisted, "The progressive realization of the right to health over a period of time should not be interpreted as depriving States parties' obligations of all meaningful content. Rather, progressive realization means that States parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of [the right to the highest attainable standard of health]."[15]

Another danger is that flexibility has the potential to open the floodgates for excuses. Does that progressive realization provision allow China to trade off possible gains in the realization of the right to health for the sake of economic development? The 1997 Maastricht Guidelines on Violations of Economic, Social and Cultural Rights state, "The State cannot use the "progressive realization" provisions in article 2 of the Covenant [ICESCR] as a pretext for non-compliance. Nor can the State justify derogations or limitations of rights recognized in the Covenant because of different social, religious and cultural backgrounds."[16]

12 P. Sieghart has observed, for example, "These standards are deliberately designed to be culturally and ideologically neutral…The distinguishing characteristic of all human rights is that they are universal." See *The Lawful Rights of Mankind* (Oxford: Oxford University Press, 1985), pp. 40 & 75.

13 L. Rubenstein, "How International Human Rights Organizations Can Advance Economic, Social, and Cultural Rights," *Human Rights Quarterly 26* (2004): 849.

14 L. Rubenstein, "Response by Leonard Rubenstein," *Human Rights Quarterly 26* (2004): 881.

15 UN Economic and Social Council, *General Comment No. 14: Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights* (11 August 2000), paragraph 31.

16 "The Masstricht Guidelines on the Violations of Economic, Social and Cultural Rights," *Human Rights Quarterly 20* (1998): 694-95.

The Paradigm of Selective Adaptation

This paper offers selective adaptation as an alternative paradigm for thinking about the flexibility of judgments of non-compliance with international obligations by China in the realm of health and human rights. Selective adaptation involves a dynamic by which international rule regimes are mediated by local cultural norms.[17] Proceeding from typologies linking international rules regimes with associated sets of normative principles, and informed by concepts linking rule compliance with the existence of normative consensus, the paradigm of selective adaptation suggests that international human rights compliance may require accommodation with local cultural norms. Thus, universal human rights standards on the right to adequate health care, for example, will in practice be interpreted according to local norms concerning such matters as the relationship between individual and collective claims, expectations about health, and the delivery of health care. The broader point is that when international rules are ratified by state parties, that ratification does not de facto make those rules local.[18] Rather, selective adaptation is the process by which those rules become localized.

The paradigm of selective adaptation may also be seen to operate by reference to factors of perception, complementarity, and legitimacy. *Perception* influences understanding about foreign rules and local norms and practices. In the area of human rights to health care, this may involve perception about what the international rule regime requires in terms of health care priorities, outcomes and processes, and perception about local conditions and expectations. *Complementarity* describes a circumstance by which apparently contradictory phenomena can be combined in ways that preserve essential characteristics of each component and yet allow for them to operate together in a mutually reinforcing and effective manner. In the health care area, for example, complementarity may help explain how international standards for assessment of health needs and delivery of health care can accommodate local social practices. *Legitimacy* concerns the extent to which members of local communities support the purposes and consequences of international standards. Thus, in the health care sector, popular reactions to state-controlled reporting on infectious diseases such as HIV, SARS and Avian Flu may signal varying levels of legitimacy for the process of localizing international standards.

While selective adaptation offers potential to understand dynamics of localization of international human rights standards, it also works to limit efforts to insulate or excuse government behavior from human rights criticism. For the key determinant in selective adaptation is the relationship between the norms underlying international human rights standards

17 See in particular P. Potter, "Globalization and Economic Regulation in China: Selective Adaptation of Globalized Norms and Practices," *Washington University Global Studies Law Review 2* (2003): 119-150, as well as note 8.

18 This claim is a general one that we believe holds not just in the case of China but also quite transparently in advanced legal systems such as the United States and Canada.

and local cultural norms. While much of the academic and policy work on the international health rights regime focuses on rule compliance, understanding such compliance requires more that simply comparing local performance against international requirements. Rather, compliance can be understood more clearly by examining the extent to which norms underlying the international regime are consonant with local norms. This can help explain compliance outcomes, by differentiating between those situations where non-compliance is the result of normative conflict and those cases where local norms are consistent with the norms of the international regime but local practices fail to satisfy international standards.

In sum, the focus on normative dynamics of compliance allows the paradigm of selective adaptation to limit the scope of claims to cultural relativism as an explanation for non-compliance with international human rights standards. Where demonstrable conflicts exist between international rule regimes and local popular norms, accommodation to cultural differences might be useful. But non-compliance unrelated to factors of normative consensus cannot be excused by reference to cultural relativism.

In correspondence to the two distinct sets of international obligations in the area of health and human rights identified at the outset, we provide a brief analysis of how China handled the SARS crisis and has treated individuals with AIDS. Through the lens of selective adaptation, we seek to judge how well China complied with its international obligations. This analysis shows why China can be viewed as eventually having been compliant with its international obligations as the SARS crisis unfolded. This assessment holds in spite of the Chinese Government's secrecy and censorship during the crisis. The relevant contrast is to how China has treated individuals with AIDS. Selective adaptation allows us to see clearly that China has failed to be compliant with its international obligations to fulfill the rights of persons with AIDS to an adequate standard of health care nor treat them in a manner that is not discriminatory. The point of these two contrasting assessments is to illustrate how the paradigm of selective adaptation enables us to assess critically whether China is complying with its international obligations in the area of health and human rights whilst still recognizing the cultural particularity of China. In particular, it helps to make visible that non-compliance with international human rights to health in China is rarely an issue of cultural differences but often a failure of local authorities to make the right to health an overriding priority.