Tropical Medicine and International Health doi:10.1111/tmi.12287

VOLUME 19 NO 6 PP 620–624 JUNE 2014

Editorial

Right to health and global public health research: from tensions to synergy?

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keywords right to health, global public health, universal health coverage, human rights

'Public health is the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society', or so argued Acheson, then Chief Medical Officer of the UK (Acheson 1988). According to international human rights scholars Gruskin and Maluwa, 'international human rights law is about defining what governments can do to us, cannot do to us and should do for us' (Gruskin & Maluwa 2002). Applied to the right to health, which means that international human rights law is about what governments should and should not do to promote people's health: thus, despite their very different origins, the two concepts are rather similar. In this paper, we shall first explore the differences behind the two concepts to better understand the natural tension between them. Second, we shall explore how this tension is heightened when they interact at the global level by examining three cases. Finally, we shall explore the possible implications for universal health coverage if public health researchers and right to health scholars work together.

Despite the similarities between public health and international human rights law, there are differences. Listing these differences is not necessary for our purpose: here, we merely intend to highlight a key difference in the emphasis each places on how to approach improving health. Those adopting a rights-based approach tend to stress the intensity of (governmental) efforts, whereas public health-based approaches tend to favour efficiency. The collective mobilisation and redistribution of (financial) resources is a cornerstone of the right to health: without public expenditure, there can be no public water, sanitation or healthcare services. The rights in the Universal Declaration of Human Rights were enshrined in two legally binding treaties, the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights, which has been ratified by 161 states (United Nations Treaty Collection Databases). Resources are at the heart of the International Covenant on Economic, Social and Cultural Rights: a state that ratifies this treaty is legally required to 'undertake to take steps, individually and through international assistance and cooperation, especially economic and technical, *to the maximum of its available resources*, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant' (emphasis added) (United Nations 1966). Efficiency is a main concern for public health scholars. They are trained to accept that '[t]here are limited resources that can be devoted to public health and the assurance of high-quality health services' and that therefore, 'an essential function of public health is to effectively plan, manage and administer cost-effective health services, and to ensure their availability to all segments of society' (Detels 2009).

Allow us to use 'Hume's Guillotine' to elaborate this tension: David Hume's (in) famous thesis that 'from what is (or is not), nothing about what ought to be (or ought not to be) can logically be concluded' (Schurz 1997). Although Hume's thesis remains controversial, it is generally accepted that statements about what *ought* to be belong to a different epistemological order than statements about what *is*. To move from a descriptive premise to a prescriptive conclusion, a second prescriptive premise is needed. For example, if it *is* true that providing potable water improves people's health, and if societies *ought* to improve the health of the people, then it can be logically concluded that societies *ought* to provide potable water to everyone.

In a mixed syllogism as the one above – with a descriptive and a prescriptive premise – lawyers' attention will be drawn to the prescriptive one. That is what they are trained for. For the descriptive premise, they have to lean on other sciences, empirical sciences. A typical right to health research paper will consider a given situation – for example, the water supply in a city has been privatised, many families cannot afford to pay for water, and there

is an upsurge of diarrhoea and infant mortality – and analyse it from an international human rights law perspective – for example, whether or not the government had other options that would safeguard people's access to water – to conclude whether the situation is or is not a violation of the right to health. In this example, the lawyers will not examine the causal relationship between reduced access to water and infant mortality; they will leave that to the epidemiologists.

Most public health scholars are trained to examine the descriptive premises of mixed syllogisms. A public health research paper on the situation described above will probably focus on the causal relationship between access to water and infant mortality, and if such a causal relationship can be demonstrated, it will recommend improving access to water. The prescriptive premise – that societies ought to tackle infant mortality – will often be implicit, and taken for granted, or borrowed from the normative sciences.

As long as the right to health and public health pull in the same direction, they make a powerful team. At times, however, they can pull in different directions. In the situation described above, public health researchers may compare different options and conclude that exemptions from payments for water for the poorest families are a relatively effective and affordable solution, while the human rights lawyers may conclude that the government can afford to provide free water for everyone, and if that would reduce infant mortality even further, that is what the government ought to do. In such a situation, right to health research and public health research can undermine each other: lawyers blaming public health scholars for formulating ineffective recommendations, and public health scholars blame human rights lawyers for inefficient recommendations.

From the national to the global level: exacerbating the tension

The natural tension between right to health and public health researchers is exacerbated when health research is practiced at the global level. If at the national level, there is 'truth' in a lawyer's statement that a government ought to do this or that, chances are that a court ruling will confirm it and force the government to act accordingly, thus the normative truth becomes an empirical truth. But there is no global government that determines the level of resources that global society should allocate to global health. Often, at the global level, the normative truth remains an empirical illusion, and legal analysis, no matter how objectively done, looks like nothing more than advocacy.

The absence of robust legal mechanisms for enforcing human rights-based normative truths allows them to be discounted or ignored. The accountability deficit means that it is common for global public health scholars to assume that the present level of available financial resources will be the future level of available resources, and to seek the most efficient solutions within that financial status quo – even if the financial status quo is wrong from a human rights law perspective. However, this strict equation of accountability with legal mechanisms does not take account of other methods of persuasion and enforcement, including the AIDS response discussed below.

One of the most famous (or infamous) examples of global public health recommendations seeking greater efficiency within the financial status quo was Walsh and Warren's recommendation (in 1979) to freeze comprehensive primary healthcare ambitions for a while and to adopt selective primary health care as a more efficient 'interim strategy', while waiting for better financial times (Walsh & Warren 1979). More recently, in 2006, Costello *et al.* supported the recommendations of Campbell *et al.* to make emergency obstetric care in health centres available and accessible to all women needing it (Campbell *et al.* 2006), but only as a longer-term strategy. Costello *et al.* argued that Campbell *et al.*'s recommendation 'might not be the best option for reducing maternal mortality in all contexts in the shorter term', because 'this strategy is simply not achievable with current resources and infrastructure', and they recommended a community-based strategy (Costello *et al.* 2006). Like Walsh and Warren, Costello *et al.* proposed a kind of 'interim strategy' which they knew was suboptimal for reducing maternal mortality, on the grounds of insufficient resources.

In hindsight, it can be argued that Walsh and Warren were 'proven' right: during the 1980s, the era of 'structural adjustment' promoted by the International Monetary Fund and the World Bank, governments of low-income countries reduced their public health expenditure (Pinstrup-Andersen *et al.* 1987). Selective primary health care may well have been the most cost-effective option in those circumstances and thus may have saved lives. The jury is still out about Costello *et al.*'s recommendations. The Office of the United Nations High Commissioner for Human Rights, in its 2012 report on 'preventable maternal morbidity and mortality', is more in line with Campbell *et al.*, and circumvents the insufficient resources argument by confirming the existence of '[o]bligations to provide international assistance and cooperation', which 'supplement but do not displace obligations of national Governments' (United Nations 2012). It is difficult to

affirm at present that most low-income countries are trying hard to provide Campbell *et al.*'s recommendations and succeeding in securing the financial and other resources that takes. Perhaps, in a decade from now, Costello at al will be 'proven' right as well.

However, it can also be argued that Walsh and Warren and Costello *et al.* formulated self-fulfilling prophecies. Perhaps Walsh and Warren paved the way for insufficient resources for comprehensive primary health care: although they admitted it was a suboptimal interim strategy, their proposal may have reduced the pressure on governments to increase financial resources for health – domestically and internationally. Perhaps Costello *et al.* paved the way for a selective maternal healthcare approach that does not require additional resources and therefore leads to stagnating resources. It is very difficult to construct a credible counterfactual. What would have happened if all global public health scholars had supported comprehensive primary health care and opposed Walsh and Warren's advice: would that have increased the pressure on governments to provide more resources, domestically and internationally? What would happen if all global public health scholars were to support the recommendations of Campbell *et al.* and of the Office of the United Nations High Commissioner for Human Rights, not those of Costello *et al.*?

We may not have the counterfactuals for those specific issues, but we do have an example of a rather consensual global public health position that rejected the financial status quo and pursued the right to health claim for increased financial resources. In 2002, Marseille *et al.* recommended scaling up HIV prevention efforts before providing AIDS treatment in sub-Saharan Africa, because of insufficient financial resources for doing both (Marseille *et al.* 2002). Like Walsh and Warren, who acknowledged that (comprehensive) primary health care was more effective than selective primary health care, and like Costello at al, who admit that health centre-based maternal health care is probably more effective than community-based maternal health care, Marseille *et al.* left no doubt about the superior effectiveness of a comprehensive response to HIV/AIDS, including prevention and treatment. Like Walsh and Warren, and like Costello *et al.*, Marseille *et al.* explicitly formulated their recommendation as an interim strategy: 'The findings and recommendations of this analysis pertain to the phasing in of additional HIV-related activities during the current period of improved but inadequate funding' (Marseille *et al.* 2002). The difference is Marseille *et al.*'s recommendation received little support from global public health scholars and was not followed; all countries in sub-Saharan Africa embarked on a comprehensive strategy, including HIV prevention and AIDS treatment, with financial and other support from the newly created Global Fund to fight AIDS, tuberculosis and malaria. Here, the counterfactual may be easier to imagine: what would have happened if Marseille *et al.*'s recommendations had been followed? Perhaps the world would have mentally 'adjusted' to millions of AIDS deaths in sub-Saharan Africa annually, like it has adjusted to so many other gross global health inequalities, and Marseille *et al.*'s recommendation could have become a self-fulfilling prophecy.

Universal health coverage: anchored in the human right to health, or not anchored at all?

Now that the world is gearing up to pursue universal health coverage, a new tension between right to health and global public health researchers is in the making: should universal health coverage be premised on the assumption of a financial resources status quo, or should it be anchored in the right to health, assuming that governments will indeed do what they ought to do, what they have legally obligated themselves to do, from a right to health perspective? (Ooms *et al.* 2013). Some global public health scholars will argue that only the first option is realistic, that what happened for the fight against AIDS cannot be easily replicated and that we should start from more realistic assumptions.

It should be understood that some assumptions about available resources are needed to flesh out the concept of universal health coverage. Whether we want to consider the health services that ought to be included in universal health coverage, the amount of the population that should be covered, or the level of financial support, a rough assumption about the available resources is required.

One option is to assume that whatever the resource envelope was in a given country last year will remain constant for the next year. Lawyers would call that an 'appeal to tradition' (argumentum ad antiquitatem), which is a logical fallacy (Bennet 2013a). Furthermore, given that the average per capita per annum government health expenditure doubled in low-income countries between 2000 and 2010 (from US$4 to $10), tripled in lower middle-income countries (from $8 to $27), quadrupled in upper middle-income countries (from $55 to $211) and doubled in high-income countries (from $1524 to $3026)(WHO 2013), it may not even be a reliable appeal to tradition.

The alternative option could be to assume that governments will finally live up to their right to health obliga-

tions – domestically and internationally. Perhaps the 'maximum available resources' formula does not give us a lot of support, but comparing what different countries do and holding them accountable for promises they made at different international platforms, allows us to make reasonable, defensible judgments about what they are able to do. The Committee on Economic, Social and Cultural Rights, which is mandated to monitor states' compliance with the International Covenant on Economic, Social and Cultural Rights, recently made the following observation to the Government of Belgium: 'The Committee recommends that the State party step up its efforts to attain the objective of increasing its international official development assistance to 0.7 per cent of [Gross Domestic Product]' (CESCR 2013). To the Government of Gabon, it observed: 'The Committee urges the State party to increase the resources allocated to the implementation of the national health policy and to draw up a timetable for meeting the Abuja Declaration target'. If all governments of low-income countries would indeed increase government revenue to a minimum level of 20% of gross domestic product (GDP) and allocate 15% of government revenue to the health sector (the Abuja Declaration target), and if all high-income countries would increase their international assistance budget to 0.7% of GDP and also allocate 15% of that to the health sector of countries that need it most, then the per capita per annum government health expenditure in low-income countries could increase to $50 (from the 2010 average of $10).

Now this is what public health scholars (with a training in logic) would call an 'appeal to faith'... and to be sure, that is a logical fallacy as well (Bennet 2013b). But it is an appeal to international human rights law as well.

Should global public health scholars follow an appeal to – as of yet unenforceable – international human rights law? We think they should, for the following reasons.

The unenforceability of international legal obligations is not a good reason for ignoring them, on the contrary. Given the absence of a global government, global health governance is, according to Fidler, 'the use of formal and informal institutions, rules and processes by states, intergovernmental organisations and non-state actors to deal with challenges to health that require cross-border collective action to address effectively' (Fidler 2010). Global public health scholars are part of global health governance, whether they like it or not, and their recommendations influence decision. The absence of a global government – which could, if necessary, correct their recommendations – does not decrease their responsibility, it increases their responsibility.

Human rights are not ordinary rights; as Wolff wrote, 'they generate a mechanism of accountability beyond the nation-state', and '[i]f a country violates the human rights of its citizens, then those outside national boundaries should sit up and take notice' (Wolff 2012). If global public health scholars ignore the demands of international human rights norms when it comes to international obligations – for lack of enforceability – then they deprive themselves of the legitimacy to tell governments what they ought to do, domestically as well. What argument could they formulate then, against governments that agree, for example, with Nozick's ideal of the 'minimal state' – a state that is not responsible for the health or general well-being of its citizens, except when it comes to protection against violence, theft and fraud (Nozick 1974)?

The concept of universal health coverage is promoted by many – including ourselves – as a way to overcome the divide between international support for poorer countries' health systems and global disease control efforts (Garrett *et al.* 2009). But the governments of the many countries providing international assistance may want to prioritise global disease control efforts, as that contributes to protecting their own citizens. If global public health scholars are reluctant to recommend universal health coverage in line with the demands of international human rights law – because they do not believe that governments of high-income countries will live up to them – why would they hope that the same governments will abandon their preference for global disease control efforts? Because of the Paris Declaration, and the promise of alignment with national priorities, perhaps? The Paris Declaration is a declaration, not a treaty, unlike the International Covenant on Economic, Social and Cultural Rights, which is a treaty, and therefore legally binding. If it is not reasonable to expect that government will comply with international human rights law, it is even less reasonable to expect they will live up to a non-binding political declaration like the Paris Declaration.

Essentially, universal health coverage that is not anchored in the right to health has no normative anchors at all. It is a free-for-all concept that may go the way of comprehensive primary health care, a fate that neither human rights nor public health scholars want repeated.

Acknowledgements

Both authors receive research funding from the Go4Health research project funded by the European Union's Seventh Framework Program. The funders had no role in study design, data collection and analysis, decision to publish or preparation of the manuscript.

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