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THE RIGHT TO HEALTH: A DUTY FOR WHOM?

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The Right to Health: What Do I Expect from a Pharmaceutical Corporation?

by Professor Paul Hunt, UN Special Rapporteur on the right to the highest attainable standard of health (the 'right to health')

In each of my annual reports to the UN General Assembly and UN Commission on Human Rights, I tackle a major theme, such as sexual and reproductive health, mental health, and so on.¹ When considering a major theme, I examine it through the prism of the right to health, highlighting the right to health dimensions.

In a forthcoming report to the United Nations, I expect to consider the right to health responsibilities of the pharmaceutical sector. This right to health issue probably attracts as much public attention as any other. So, at some point, I wish to address it, while striving to be balanced and constructive.

Thus, I am especially pleased to have the chance to listen and discuss with you all today.

In this paper, I do not answer the question 'what are the right to health duties of the pharmaceutical sector?' Instead, what I try to do is more modest: I try to signal a measured *approach* to that complex question.

My closing remarks include a practical, specific proposal to take the issues forward.

What does the right to the highest attainable standard of health mean?

In my various reports, I have begun to set out the scope of the right to health. I will not repeat this exercise here. Instead, I make just a few observations.

The right to health is codified in numerous legally binding international and regional human rights treaties. These binding treaties are beginning to generate case law and other jurisprudence that shed light on the content of the right to health. The right to health is also enshrined in numerous national constitutions: over 100 constitutional provisions include the right to health or health-related rights. Moreover, in some jurisdictions constitutional provisions on the right to health have generated significant jurisprudence.²

The right to health includes the right to health care, but it goes beyond health care to encompass safe drinking water, adequate sanitation and access to health-related information. The right includes freedoms, such as the right to be free from

¹ For my latest report, to the General Assembly, see A/59/422 dated 8 October 2004.

² Eg the Argentinian court case of *Viceconti v. Ministry of Health and Social Welfare*, Poder Judicial de la Nación, Causa no. 31.777/96, 2 June 1998.

discrimination, both in law and fact. It also includes entitlements, such as the right to a system of health protection. The right has numerous elements, including child health, maternal health, and access to essential drugs. Like other human rights, it has a particular preoccupation with the disadvantaged, the vulnerable, and those living in poverty. The right requires an effective, inclusive health system of good quality.

International human rights law is realistic and recognises that the right to health for all cannot be realised overnight. Thus, the right is expressly subject to (i) progressive realisation and (ii) resource availability. Although qualified in this way, nonetheless the right to health imposes some obligations of immediate effect, such as non-discrimination. It demands indicators and benchmarks to monitor the progressive realization of the right. The right to health also encompasses the active and informed participation of individuals and communities in health decision-making that affects them. Under international human rights law, developed States have some responsibilities towards the realization of the right to health in poor countries. Because the right to health gives rise to entitlements and obligations, it demands effective mechanisms of accountability – an issue I return to below.

Our understanding of the right to health is not yet as deep as our understanding of some of the classic civil and political rights – there are historical reasons for this that I will not explore today. Nonetheless, our knowledge of the right to health is deepening. Of course, there are grey areas - and there are also good-faith disputes and disagreements, just as there are in relation to the classic civil and political rights, and all fields of inquiry.

May I emphasise two important points. *First*, the right to health is not a slogan: it has something constructive and concise to offer those who are committed to improving health care and health protection for all. *Second*, our understanding of the scope of the right to health has reached a crucial formative stage - it is not yet settled - on the contrary, it is rapidly evolving.

Human rights and balance

Human rights reflect the importance of balance. Few human rights are absolute. Most demand some sort of balance to be struck between competing rights, values or interests. Freedom of information has to be balanced against privacy and confidentiality. Freedom of expression has to be balanced with the prohibition against the incitement to racial hatred. For the most part, the right to health is subject to resource availability, a formula that compels a State to make choices between competing claims on the public purse. In other words, striking balances is a fundamental feature of human rights. We do it all the time.

If we are to address the problem of access to essential drugs for all, including those living in poverty, an appropriate balance will have to be struck between various legitimate interests, such as: the human right of sick people to essential medicines; our common interest in fostering an optimum level of useful research and development; and the interests of the pharmaceutical companies and their shareholders in making money.³ This weighing of various interests is very familiar human rights territory.

³ Sarah Joseph, “Pharmaceutical Corporations and Access to Drugs: The ‘Fourth Wave’ of Corporate Human Rights Scrutiny”, *Human Rights Quarterly* 25 (2003) 425, at 451. That is not to say that all legitimate interests have equal weight.

The indispensable contribution of human rights is that they help to ensure that the interests of the relatively powerless are not neglected but given due weight throughout the balancing process.

The emblematic human rights feature: accountability

Human rights empower individuals and communities by granting them entitlements and placing obligations on others. Crucially, rights and obligations demand accountability: unless supported by a system of accountability they can become no more than window-dressing. Thus, a human rights – or right to health – approach emphasises obligations and requires that all duty-holders be held to account for their conduct.

All too often, ‘accountability’ is used to mean blame and punishment.⁴ But this narrow understanding of the term is much too limited. A right to health accountability mechanism establishes which health policies and practices are working and which are not, and why, with the objective of improving the realisation of the right to health for all. Accountability comes in many forms. In relation to a human right as complex as the right to health, a range of accountability mechanisms is required and the form and mix of devices will vary from one jurisdiction to another. They may also vary from one type of duty-holder to another.

Although large issues remain, in recent years some pharmaceutical companies have made significant progress in relation to their corporate social responsibility.

However, I am struck by the absence of accessible, effective, transparent and independent accountability mechanisms in relation to corporate social responsibility. Some reporting initiatives are impressive, such as the Novartis publication *Improving Access to Leprosy Treatment*, GlaxoSmithKline’s *Facing the Challenge: Two Years On* and DFID’s *Increasing access to essential medicines in the developing world*. Public candid self-reporting is very welcome. But self-reporting is no substitute for an independent accountability mechanism. It is in this regard that I make a suggestion at the end of these remarks.

Is the pharmaceutical sector bound by international human rights law?

It is widely agreed that a State has an obligation to ensure that all third parties in its jurisdiction, including pharmaceutical companies, are respectful of human rights. The more difficult question is whether or not the pharmaceutical sector is itself subject to international human rights law.

I am not going to explore this question in any detail. There are already a number of useful papers and articles on this topic. The terrain is now well-traversed. I would just make these brief personal observations.

At root, human rights are about the abuse of power. They are designed to stop -- or at least reduce -- the abusive exercise of power. Contemporary human rights emerged from the crucible of the Second World War. At this time, the main power-holder - and

⁴ See L.P. Freedman, “Human rights, constructive accountability and maternal mortality in the Dominican Republic: a commentary”, *International Journal of Gynaecology and Obstetrics*, vol. 82 (2003) pp. 111-114.

the main abuser of power - was the State. The Charter of the United Nations was drafted as the Allied Powers opened the gates of Auschwitz. Naturally, therefore, contemporary human rights are primarily designed to reduce the abuse of *State* power.

Today, States remain powerful. But there are other powerful actors in the world, including those in the private sector. Since human rights are fundamentally about the control of power, it is inevitable that, in time, they should be extended to powerful non-State actors. The *application* of human rights may vary from one type of actor to another. For example, a State may be required to implement a human right in one way (eg enact laws) and a non-State actor in another (eg reduce prices for those living in poverty). But, in my opinion, the internal logic of human rights will inevitably lead to their application, in one form or another, to non-State actors.

Of course, some argue that it is dangerous to extend human rights to non-State actors because, they argue, these non-State actors will then want to be at the negotiating table along side States. This argument fails to recognise that the interests of some non-State actors are already very well represented at the negotiating table.

In practical terms, what can the pharmaceutical sector do to enhance realisation of the right to health and access to medicines?

Numerous publications provide recommendations on what the pharmaceutical company can and should do to improve access to medicines – consider, for example, *The Public Health Crisis in Emerging Markets*, published by the Pharmaceutical Shareowners Group,⁵ and *Beyond Philanthropy*, published by three reputable non-governmental organisations.⁶ In effect, these publications make recommendations that signal how pharmaceutical companies can enhance enjoyment of that part of the right to health that relates to access to medicines.

For example, *Beyond Philanthropy* suggests that:

- companies publish a list of pricing offers made to developing countries, with any conditions attached;
- price reductions cover a range of products that are relevant to health priorities in developing countries, not just one or two ‘flagship drugs’;
- companies do not lobby governments to include TRIPS-plus provisions in bilateral or multilateral trade agreements that are under negotiation;
- companies ensure JPPIs benefit the most vulnerable members of communities;
- companies publish their R&D target expenditure on infectious diseases;
- companies support and comply with WHO Guidelines for Good Clinical Practice for trials on pharmaceutical products.⁷

I will be very interested to hear what you think of these and other interesting recommendations that would appear to resonate with implementation of aspects of the right to health.

⁵ 2004.

⁶ Published by Oxfam, VSO and Save the Children in 2002.

⁷ *Beyond Philanthropy*, Oxfam, VSO and Save the Children, 2002, page 6.

However, for present purposes, my main point is that there is no shortage of good ideas about what the pharmaceutical sector can do to enhance implementation of the right to health and essential medicines.

Three steps

If we are to work out the right to health responsibilities of the pharmaceutical sector, I suggest we have to take three basic steps.

First, we have to clarify the nature of the obligation of the pharmaceutical sector in relation to the right to health. Does the pharmaceutical sector have precisely the same obligation as a State? Or does it have a more limited – but nonetheless binding – obligation?⁸

Second, whatever the nature of the obligation, what precisely does the obligation apply to?⁹ For instance, access to essential drugs is an integral component of the right to health. So the pharmaceutical sector's obligation (whatever its nature) certainly applies to essential drugs. But the issue of essential drugs is itself a large box -- what lies inside it? According to *Beyond Philanthropy*, the issue of essential drugs can be unpacked into five topics: pricing, patents, Joint Public Private Initiatives (JPPI), research and development, and the appropriate use of medicines. If that is correct, we have to apply the pharmaceutical sector's obligation to these five important topics.

Third, as we endeavour to apply the pharmaceutical sector's obligation to these five topics, we must use the analytical frameworks provided by human rights. As briefly as possible, let me take one analytical framework provided by the right to health and apply it to essential drugs in relation to a Least Developed Country (LDC), such as Mozambique.

Under the right to health, Mozambique has to do all it reasonably can to make an essential drug *available* to its people. For example, it might have to pass and use compulsory licence legislation - in other words to use the TRIPS flexibilities that are quite properly available to it.

But the availability of the essential medicine is not enough. According to the right to health, Mozambique has to do all it reasonably can to ensure that the essential drug is *accessible* to all, especially those living in poverty. The drug cannot just be accessible in the urban areas or to the rich or to some ethnic groups and not others. This right to health requirement of accessibility means one has to think creatively about delivery mechanisms: mobile clinics, mopeds for nurses, para-medics and so on.

The right to health requirement of *accessibility* might also mean that the LDC has to revisit any import duties it imposes on the essential drug, because import duties could make the drug inaccessible to people living in poverty.

But the right to health notions of availability and accessibility are not enough either - the essential drug has to be of *good quality*. Sometimes drugs have passed their expiry

⁸ As lawyers might put it: does a State's general legal obligation, as set out in article 2 of ICESCR, also apply to the pharmaceutical sector?

⁹ The short legal answer is article 12 of ICESCR and other provisions of human rights law bearing upon the right to health.

date and so have been rejected in the North - and only then are made available in the South. Sometimes the drugs have been interfered with. So the right to health requirement of *good quality* essential drugs means Mozambique must have in place a basic system for the monitoring and checking of essential drug quality.

In short, the right to health analysis of *availability, accessibility* and *good quality* can, in relation to essential drugs, help to identify practical and precise policy interventions that will help to ensure all in Mozambique enjoy this element of the right to health.¹⁰

Here I have used the framework – availability, accessibility, quality - that *States* should apply. Whether or not the *pharmaceutical sector* is also obliged to apply precisely the same framework is not yet clear, as I suggested earlier. But, whether or not the pharmaceutical company is obliged to apply this framework, in any event its application might help to identify policy interventions that a pharmaceutical company can take to improve access to essential drugs and thereby help to realise this vital element of the right to health.

The right to health duties of the pharmaceutical sector: a way forward

I suggest that those of us who wish to clarify the right to health duties of the pharmaceutical sector have to confront two major challenges.

First, we have to identify what can be properly required of the pharmaceutical sector. What is it *obliged* to do?

Second, we have to devise appropriate accountability mechanisms to monitor whether or not pharmaceutical companies are doing what they are required to do - not with a view to blame and punishment but with a view to identifying which health policies and practices are working and which are not, and why, in the context of the right to health for all.

With these challenges in mind, I make a two-part suggestion for your consideration. Each part corresponds to one of the challenges I have just identified.

First, I suggest that a small group of ‘experts’, from the human rights community and from the pharmaceuticals, closely examine the right to health responsibilities of the pharmaceutical sector. The experts should meet three or four times a year over a period of two years. They should be supported by a small secretariat that prepares background papers. They would need a modest budget to commission research. But the aim of the initiative would not primarily be to generate new research, rather to stimulate new insights from existing materials. Supported in this way, the small group of ‘experts’ would apply the right to health paradigm to the pharmaceutical sector, try to identify common ground and, where they exist, clarify differences of opinion. The group would aim to agree a final report that ranges over the key issues, deepens understanding, identifies both common ground and differences of opinion, and suggests next steps.

¹⁰ For completeness I note that the analytical framework mentioned here includes a fourth component - *acceptability* - which I have omitted in these remarks in the interests of brevity. Acceptability is identified in CESCR’s General Comment 14.

After Part I is completed, I suggest an *ad hoc* group of independent experts is established, for an experimental period of three years, to periodically review the policies and practices of pharmaceutical companies from the point of view of the right to health. The *ad hoc* group of independent experts would produce short, accessible, public reports. Of course, these reports would not be binding on the companies. But they should be even-handed, constructive and persuasive.

So this would be a five-year project. Part I would tease through some of the normative and policy issues. Part II would provide, on an experimental basis, a modest form of independent accountability. The two parts are inextricably linked. They are a package. They should not be de-linked.

Of course, this quick sketch leaves many questions unanswered, not least who would select the two groups of experts? Which companies would be subject to review by the second group – that is by the *ad hoc* group of independent experts? How could the scope of both groups be kept focussed and manageable?¹¹ However, with political commitment and a modicum of goodwill, these and other questions can be sorted out.

In any event, I put the idea on the table for discussion.

Paul Hunt,
UN Special Rapporteur on the right to health,
University of Essex, England,
University of Waikato, New Zealand,

December 2004.

¹¹ One challenge is to move from the general to the specific, from the right to health generally to access to medicines (and other sub-sets of the right to health) more specifically. To facilitate this specificity, the scope of the two groups should be quite narrow.