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The Human Right to Health and the Challenge of Poverty

Patrick Hayden

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Abstract and Keywords

The human right to health has assumed considerable prominence as one of the most pressing international issues of the twenty-first century. This chapter examines arguments regarding how the mutually reinforcing cycle of poverty, inequality, and poor health affects the disease burden around the world, and considers why the right to health is widely compromised by global health disparities. It first traces the evolution of international concern with health as a basic human right. The following section discusses two competing frameworks—statist and globalist—for conceptualizing the meaning and value of health within current international policy. The final section analyses the right to health in terms of recognition theory's emphasis on the intersectional injustices of poverty and inequality, which have deleterious effects on health as well as on identity and self-respect.

Keywords: burden of disease, globalism, global health, human rights, inequality, poverty, recognition, right to health, social determinants of health, statism

THE right to health is enshrined in international human rights treaties yet is widely compromised by global health disparities. Across the world, more than 2.2 billion people live in conditions of multidimensional poverty, comprising lack of income, poor nutrition, and inadequate sanitation and clean water, as well as structural barriers to accessing health resources (UNDP 2014: 3). Severe poverty has devastating consequences for health. Approximately one third of all deaths each year are due to poverty-related health risks (malnutrition, unsafe water, poor sanitation and hygiene), and preventable communicable diseases (pneumonia, diarrhoeal diseases, HIV/AIDS, malaria, measles, tuberculosis) (UNDP 2013; WHO 2015a: 14–17). Globally, citizens of poorer countries are disadvantaged in terms of mortality, life expectancy, health expenditure, and health service coverage in comparison to the citizens of wealthier countries. The World Health

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Organization (WHO) estimates, for instance, that at least 1.3 billion people lack access to basic health services, and nearly a third of the global population—including over half of those living in Africa and Asia—lack access to essential medicines (WHO 2011). The mutually reinforcing cycle of poverty, inequality, and poor health affects the disease burden around the world: low- and middle-income countries bear 93 per cent of the world's disease burden, yet account for only 18 per cent of world income and 11 per cent of global health spending (WHO 2000: 7; 2013: 37).

This chapter considers legal, moral, and political articulations of the right to health, alongside the challenges posed to health status by poverty and socioeconomic inequality. The first section traces the evolution of international concern with health as a basic human right worthy of protection and fulfilment. Despite its uneven implementation globally, the right to health is increasingly acknowledged as a justified claim on governments to provide access to adequate health services and treatment. The second section discusses two competing frameworks for conceptualizing the meaning and value (p. 358) of health—a statist framing of securitization and a globalist framing of individual entitlement—as examples of how the right to health faces uncertainty associated with current international policy decisions. Although health is often viewed by states as a residual category of wider security interests, globalists contend that this view diminishes responsibility for the social determinants of health essential to enjoyment of the right to health itself. The third section proposes an understanding of the right to health in terms of recognition theory's emphasis on the intersectional injustices of poverty and inequality, which refers to the ways that material deprivation and social exclusion compound each other. Analysing the right to health in these terms, I argue, should lead us to think more expansively about the deleterious consequences of poverty and inequality on the health, identity, and self-respect of those who are not recognized as fully human persons.

Health as a Basic Human Right

The right to health has assumed greater prominence on the social science agenda since the early 2000s, driven by the concerns of scholars, policy-makers, and social movements about the adverse implications of globalization on economic and social rights. Once considered "the neglected stepchildren of the human rights movement" (Farmer 2003: xxiv), socioeconomic rights now attract an enormous amount of writing, largely centred on analysis of the pathways through which their realization can take place. Despite this increasing interest in socioeconomic rights generally, study of the right to health in particular remains surprisingly modest in International Political Theory (IPT). The majority of analyses of health and human rights comes from the fields of international law, health studies, sociology, bioethics, and philosophy. Norman Daniels (2008) has formulated a modified Rawlsian account of just health policy, for example, positing health care as central to the fair distribution of income, wealth, and opportunities. Yet even for Daniels, health becomes a focus of justice only indirectly, insofar as it matters for

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resource allocation and equality of opportunity. Similarly, Simon Caney (2010) refers to the vital interests we have in the rights to life, health, and subsistence, but attention to these rights is bounded by his overarching consideration of climate change. Thus, IPT still has pressingly important contributions to make in clarifying both the significance of the value of health for its own sake and the role that health plays as an important dimension of human wellbeing within an international context.

While representing a variety of approaches and theories, current research on the right to health turns, in essence, on the constituent norms of the international human rights system. The idea that health is a human right was first articulated in the preamble to the 1946 WHO constitution, and was subsequently included in Article 25(1) of the 1948 Universal Declaration of Human Rights (UDHR): “Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care.” The 1966 International Covenant on (p. 359) Economic, Social and Cultural Rights (ICESCR) also codifies “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,” and requires states parties to take steps individually and through international cooperation to progressively realize this right, subject to “the maximum of their available resources.” Such measures include the prevention, treatment, and control of epidemic diseases, the provision of antenatal and neonatal primary care, and the creation of social conditions to assure adequate medical attention to all. The principle of “progressive realization” acknowledges that enjoyment of the right to health depends upon the circumstances prevailing in any given context, as well as the need for states to prioritize the allocation of scarce resources (financial, technological, natural, and organizational). Nonetheless, states remain obligated to ensure the allocation of “adequate” resources to secure the immediate “effective” implementation of the right to health—including through international assistance—while taking steps to develop health system capacities (UNHCHR and WHO 2008).

The right to health is further codified in a number of other international human rights instruments, and is frequently presented as part of a configuration of related rights focused on alleviation of suffering and enhancement of wellbeing. For instance, the Human Rights Committee—the treaty monitoring body for the 1966 International Covenant on Civil and Political Rights—has broadly interpreted the right to life (Article 6) as requiring states to implement measures targeted at reducing infant mortality and preventing malnutrition and epidemic disease (UNHRC 1982). The 1979 Convention on the Elimination of All Forms of Discrimination against Women, noting that “in situations of poverty women have the least access to food, health, education, training and opportunities for employment and other needs” (Preamble), mandates that states parties take steps to eliminate discrimination against women in the field of health care, and to ensure equality of access to health care services, including those related to family planning (Article 12). The 1989 Convention on the Rights of the Child confirms that childhood is entitled to special care related specifically to “physical and mental health” (Article 17), including the right to life and development (Article 6), and states are bound to adopt measures to diminish infant and child mortality, ensure medical

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assistance and primary health care, combat disease and malnutrition, provide clean drinking water, and offer information and education related to health, nutrition, and sanitation (Article 24). Each of these instruments situates the right to health in relation to fundamental principles of non-discrimination and equality, emphasizing that the right to health is mutually constitutive of a host of other human rights. In short, human life, wellbeing, and dignity cannot survive in conditions of chronic poverty, economic and political inequality, and neglect or denial of health services.

The human right to health is by its nature what Henry Shue calls a “basic right.” Rights are “basic” if and when “enjoyment of them is essential to the enjoyment of all other rights,” and they specify the “line beneath which no one is to be allowed to sink” (Shue 1996: 18–19). Shue identifies security, liberty, and subsistence as mutually dependent basic rights because they are constitutive of the fulfilment of every other right. The correlative duties flowing from the three basic rights—to avoid depriving individuals (p. 360) of their rights, to protect individuals from deprivation, and to aid the deprived (see Chapter 41)—are therefore necessary conditions for the effective exercise of all other rights (Shue 1995: 52). The Committee on Economic, Social and Cultural Rights likewise argues that the right to health is “indispensable for the exercise of other human rights” (UNCESCR 2000: para. 1). Since an individual’s standard of health is of central importance for the full enjoyment of all human rights, both socioeconomic and civil-political, characterizing the right to health as a basic right seems apt. This is especially clear when considering how the right to health should be guaranteed for those facing “formidable structural and other obstacles” (UNCESCR 2000: para. 5), such as poverty, inequality, discrimination, and persistent burden of disease.

As a basic right, the right to health cuts across the traditional negative/positive dichotomy often used to distinguish civil-political and socioeconomic rights. On one hand it refers to the right not to have one’s health harmed by acts that infringe upon one’s bodily integrity, such as torture and medical experimentation. Yet security rights are jointly necessary with basic subsistence rights, such as the provision of primary health care services, safe drinking water, adequate food and sanitation, basic health education, reproductive and child healthcare services, and access to essential medicines (UNCESCR 1990: para. 10). On the other hand, then, the right to health cannot be realized adequately simply through non-interference by the state. As a right to certain benefits and assistance, it requires positive action to be taken in order to ensure access to health services, treatment and support for all individuals, and for public health to be protected by suitable social measures. Failure to implement such measures implies deprivation of individuals’ life and wellbeing, and violation of states’ obligations to respect, promote, and fulfil the right to health.

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Health Security and the Social Determinants of Health

Under closer scrutiny, however, the position of the right to health is more ambiguous than international legal developments suggest. Conflicting pressures emerging from an often polarized international health regime contribute to situating health at the heart of a contradictory tension between statism and globalism. While states seek to maintain comprehensive control over their borders in order to protect their populations from exogenous health-related risks and hazards (Amon 2014), they also face compelling political pressures to promote policies improving health equity so that all individuals have "secure access" (Pogge 2008: 71) to the right to health. Both aspects of "health security" evidently are a good thing. Protection against threats to life, liberty, and physical security is commonly acknowledged as a social good that states have a responsibility to provide for their citizens. Similarly, having secure access to the contents of basic rights to subsistence and health care is also generally regarded as a social good. But it is a thornier (p. 361) question as to whether state duties to mitigate against threats (real or imagined) to public health and security, or achieving effective individual rights to health and subsistence, should be accorded priority in practice. As Shue (1996: 61) recognizes, the coercive powers of states to impose extensive security measures can have deleterious effects on individual human rights.

While understandable as a pragmatic strategy to minimize a select population's exposure to contagion in an interconnected world, the statist security approach easily turns into powerful foreign policy and economic considerations that benefit only a relatively small number of people. This approach also functions to legitimize a reductive picture of unitary global health threats that glosses over different vulnerabilities concentrated among the world's poor. The United States and the United Kingdom, for example, now directly reference infectious disease threats as central to their "smart power" national security strategies (Nunes 2014). But the tendency to adopt reductive accounts of what counts as a health threat is not simply a product of pragmatic strategizing by states individually; it is also a reflection of the problematic recent development of a new and extremely potent capacity for international health governance consolidated under the generic umbrella of health security. Since the adoption of new international health regulations in 2005, a coordinated system of global health regulation has emerged that aims to define the objects and modalities of disease regulations beyond and between states, and which prioritizes infectious diseases surveillance. In 2014 the US also spearheaded the "Global Health Security Agenda," an international mechanism comprising more than thirty states and international organizations that seeks to "accelerate progress toward a world safe and secure from infectious disease threats and to promote global health security as an international security priority" (CDC 2015). This statist lens highlights the spectre of naturally occurring pandemics, such as the recent SARS, H1N1, and Ebola epidemics, as well as intentional contagions resulting from

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bioterrorism and the deliberate spread of viruses, germs, and pathogens. By reifying a heavily securitized conception of health, this lens epitomizes a growing fear of "emerging" diseases and of new risks "slanted towards the priorities of western nations" (Brown 2011: 324).

There is, then, a dramatic difference between two primary approaches to conceptualizing global health which reflect divergent normative priorities, the power of agenda-setting, and the translation of ethical-political principles into policy objectives and health outcomes. The statist approach prioritizes the interests of states and their respective populations, and searches for new modes of diplomatic, economic, and foreign policy that strengthen the capacity of (some) states to respond to and control perceived health risks. The globalist approach, in contrast, prioritizes the rights and interests of individuals across all countries, and looks for new measures of health equality that support substantial values about interdependent basic rights and transnational mechanisms for enhancing health as a requisite to human wellbeing (Davies 2010). A globalist, human rights approach thus indicates two conceptual and normative weaknesses of the statist understanding of health. One is that the push by states in the global North to strengthen infectious diseases surveillance out of a concern for discrete events characterized as acute "emergencies" and "crises" justifies an extreme focus on epidemiological (p. 362) "risk management"—accentuating techniques of containment, quarantine, and isolation—rather than on long-term expansion of adequate health and social infrastructure, improvements in living conditions, and treatment of non-communicable ailments afflicting the global South—such as the preventable diarrhoeal diseases closely linked with poverty from which millions of "vulnerable and socially disadvantaged people" die every year (Kamradt-Scott and McInnes 2012; WHO 2015b). Another weakness is that the reductive conceptualization of health adopted by the statist approach, which views health as a matter of "negative" security or survival from existential threats, brings with it several disturbing implications (Brown and Stoeva 2014: 306). First, it masks the normatively significant role that health plays in a broader picture of human wellbeing and what it means to live a properly human life. Second, it equates the health interests of individuals and the health interests of states, which do not necessarily overlap or converge. Third, it reclassifies human rights violations as generic threats to physical security, diverting attention from states' obligations to promote basic socioeconomic rights. Finally, it represents health issues in isolation from the multidimensional social conditions that strongly shape patterns of individual and group health—which are often structured along the fault lines of poverty, inequality, and discrimination—thereby privileging respect for state sovereignty over respect for individual rights (Lakoff 2010). Indeed, the rise of state control over public health in terms of transnational health securitization has occurred at a time where the combination of neoliberal economic policies, global terrorism and counterterrorism, and the post-2008 global financial crisis has eroded promotion and protection of socioeconomic rights.

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The argument here is not that addressing “health security” is unimportant, since protection from disease is beneficial, but that prioritizing securitization skews the referent object of health needs, privileges only a small proportion of threats to health, and reflects the narrow concerns of the most powerful and wealthy states (Rushton 2011: 782–4). The central issue at stake is that health is far more than survival from existential threats; it is also about the quality and condition of existence itself. The enjoyment of the highest attainable standard of health is integral to living with dignity, to cultivating personal agency, to participating in the life of one’s social, political, and economic communities, and to exercising a full spectrum of valued rights and liberties. When health is understood as a vital interest of all individuals, both as a positive state of human wellbeing and as a basic right necessary to the exercise of all other human rights, it follows that health is not merely instrumental to statist ends but has an intrinsic value. Consequently, over the past decade movement towards a globalist approach to the poverty–health nexus has positioned the interpretation of health as an individual entitlement within the broader framework of the underlying systemic and socioeconomic determinants of health. This echoes the definition of the right to health in the WHO Constitution, couched in terms of the “enjoyment of the highest attainable standard of health [. . .] without distinction of race, religion, political belief, economic or social condition.” The ICESCR similarly frames the right to health as a guarantee of “the highest attainable standard of physical and mental health,” foregrounding a socially expansive view of health and the role of non-medical social factors in contributing to health inequalities.

(p. 363) According to the authoritative interpretation offered by the UN Committee on Economic, Social and Cultural Rights General Comment 14 (UNCESCR 2000: para. 12), the right to health contains four “interrelated and essential elements” which apply to health care, public health, and the social determinants of health. In fulfilling the right to health, states have an obligation not only to protect individuals from interference with their enjoyment of this right, but also to take social measures that ensure health goods, services, and facilities are (1) available in sufficient quantity; (2) accessible to everyone without discrimination, including being affordable and geographically accessible; (3) acceptable, including ethically, culturally and with respect to privacy; and (4) of good quality and scientifically appropriate. Particular emphasis is placed on conceptualizing the underlying social determinants of health as supra-individual factors that strongly influence realization of the right to health itself. Such determinants include safe and potable water; safe and nutritious food; sanitation; housing; occupational and environmental hygiene; health information and education; employment and economic opportunities; gender and racial equality; and social inclusion. Anchoring the right to health in its underlying social determinants means it is not to be construed as a right to be “healthy.” Rather, it is “a right to the enjoyment of a variety” of diagnostic, curative, and preventive “facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health” (UNCESCR 2000: para. 9). The evolving social determinants paradigm gained further momentum as a basis for universal health norms when the WHO established the Commission on Social Determinants of Health (CSDH) in

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2005. In its final report published in 2008, the CSDH recommended shared domestic and global responsibility to address three core health areas going forward: (1) improving the daily living conditions in which individuals are born, grow, live, work, and age; (2) tackling the "deeper social structures and processes" that shape those conditions, specifically the inequitable distribution of power, wealth, and resources within and across countries; and (3) researching and measuring the multidimensional causal factors that undermine health outcomes and health equity (CSDH 2008: 202–6). In this way, the social determinants paradigm extends beyond the traditional biomedical model of health—understood as the absence of physical disease or defect irrespective of contributing social factors—exploited by the statist approach. More broadly, it reminds us that health is not merely about having or not having certain things, but more importantly about the quality and condition of a broad spectrum of social arrangements that protect, promote, or restore each individual's capability to be healthy (Sen 2002).

Poverty and the Right to Health through the Lens of Recognition

From a human rights perspective, an emphasis on the social determinants of health is appealing because it focuses attention on the need to adopt broad measures to counteract (p. 364) patterns of poverty and inequality precipitating global health inequities, and to direct such interventions to the most marginalized and vulnerable communities. Strong correlations exist between poverty, inequality in access to the social determinants of health, and the forms of vulnerability that deepen and perpetuate conditions of poor health amongst lowest income groups worldwide. Moreover, health inequalities are exacerbated by social discrimination and political exclusion on the grounds of race, ethnicity, gender, sexual orientation, religion, and language. These linkages suggest that social, economic, political, and health status are co-determined. While material deprivations deeply affect the ability of the poor to obtain services and conditions necessary for the realization of the highest attainable standard of health, my claim here is that inequalities of power, status, and political voice are also constitutive of the experience of persistent health inequalities as a global phenomenon. As a consequence, health inequalities are partly rooted in a reluctance to acknowledge the social determinants of health inequalities and their situational specificity for marginalized individuals and groups subject to unequal social relationships of poverty, discrimination, and stigmatization—a reluctance that may be overlooked by an overly narrow resource-distribution paradigm. A more effective and normatively compelling approach to the ongoing struggle for the right to health, I shall argue, focuses attention on how routine forms of misrecognition, alongside maldistribution, diminish the human status of those most vulnerable to health disparities.

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To better understand why inequalities of status, power, and voice, in addition to material scarcity, translate into health deprivations, it is helpful to turn to a “recognition theory” approach to human rights that allows us to see human rights as sites of political struggle over what makes us the same and what makes us different from one another—struggles, in other words, for due recognition of our always precarious human status. While the prevailing view about human rights in international relations relies upon the presumption of a presocial rights-bearing subject whose inherent dignity transcends the various contexts in which deprivation occurs, recognition theories highlight the distinctive forms of power and status that condition the lives of embodied individuals and groups, and the historically and politically situated nature of rights claims emerging from social struggles against injustice. This has the benefit of bringing back into view the specifically political dimension of human rights—that is, the ways that human rights claims are catalysed by the experiences of disrespect, humiliation, and a sense of powerlessness inextricably bound up with the many dimensions of material and social disadvantage.

A recognition approach articulates the situatedness of human rights as political claims to a fully human status that we acquire through our constitutive social relationships. The ability to exercise rights is dependent not only upon the juridical enshrinement of rights in positive law, but even more fundamentally upon the existence of intersubjective relations through which individuals acquire their sense of identity, self-confidence, self-respect, and self-esteem as states of wellbeing (Honneth 1995). This contrasts with the conventional “liberal consensus” on human rights (Evans 2002: 199), which reflects an overly abstract understanding of “inalienable” rights as possessed by all human beings simply in virtue of their humanity and independently of all forms of social recognition. Yet human dignity is not simply an inherent or natural fact; it is a sociopolitical condition (p. 365) that comes from being recognized by another as human (see Chapter 46). Dignity, in other words, is an interpersonal status acquired by intersubjective means of equal recognition acknowledging due respect for the worth and particularity of others. Proponents of the notion of inherent rights might argue that a recognition theory of rights is unable to provide a satisfactory account of the (intrinsic) worth of human beings, and thus is unable to offer a secure normative foundation for critiquing injustice. A recognition theory of rights can counter, however, that intrinsic moral worth itself, independently of active social recognition, does not give rise to the *status* of right holder. Without the mutual acknowledgement by a community of others of one’s equal standing as a human person, one is effectively without rights insofar as human rights constitute a social practice formed through reciprocal recognition within the political realm. As practices of social recognition, rights confer an effective political status that thereby acknowledges the justice (or injustice) of certain ways of acting and being treated. The recognition approach thereby (re)politicizes both rights and human status, since these can be won or lost within the continuous dynamics of recognition and misrecognition in the political realm. The danger of an inherent-rights approach is that it overlooks complex ways that inequalities in status have been and continue to be depoliticized. As recognition

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theory emphasizes, possessing rights is not "a matter of being constituted in a certain way" but "of being afforded a certain sort of social recognition" (Darby 2009: 132).

As with both the basic rights account and the social determinants view of health, then, the recognition approach is deeply concerned with social relationships that involve the imposition of unjustified status inequalities (economic, juridical, political, cultural) giving rise to disempowering experiences of disrespect, stigmatization, or exclusion of certain individuals or groups from claiming rights (Honneth 2007). All three approaches bring to our attention the often-overlooked interplay between forms of economic deprivation and sociocultural misrecognition. Moreover, recognition theory discloses how political exclusion and socioeconomic deprivation are mutually reinforcing bases for the denial of equal human status and thus the deprivation of human rights. To be impoverished, malnourished, a racial, ethnic, gender, or sexual minority, disabled or suffering disease and chronic illness are conditions commonly treated as pathological "defects" (as on the biomedical model) or "threats" (as on the securitization model) exhibited by the less-than-human. Poor health has a potential for social stigmatization when regarded as a deviation from "normalcy." This is why the link between health status and social, economic, and political status is crucial to the human right to health. For the right to be effectively enjoyed, it is insufficient to be formally granted a legal entitlement, since numerous social factors—including poverty, discrimination, pollution, and illiteracy—negatively impact the ability of some individuals or groups to gain due recognition as legitimate and equal rights-bearers. Often those who disproportionately bear the burden of ill-health are also those subject to misrecognition—not heard, seen, or wanted as equal persons in the sociopolitical realm. Poor health can then become a marker that attaches inferior status to misrecognized individuals and groups.

It is no coincidence that "post-Westphalian" social movements of the poor and socially excluded increasingly frame their struggles for "participatory parity" and "equal (p. 366) voice" (Fraser 2008) in terms of human rights that are conditioned by deeply contextual asymmetries of misrecognition. The dynamics of misrecognition are, for instance, historically associated with the struggles against religious intolerance and against slavery, for worker's rights and for women's suffrage, and, more recently, for indigenous peoples' rights as well as for health care justice. Because health inequalities and lack of access to adequate health care services, treatment, and essential medicines are problems that affect individuals and groups in the global South as well as the North, promotion of the right to health is part of a growing global struggle against geopolitical structural asymmetries bracketing the right to health outside the dominant statist frame of surveillance and control. The ongoing global movement for healthcare justice consists of numerous groups, NGOs, coalitions, and collaborative networks engaged in direct action, both intra- and transnationally, to promote provision of the goods, services, and conditions necessary for the realization of the highest attainable standard of health on affordable, equitable terms to all persons. Notable examples include the Treatment Action Campaign (TAC) in South Africa, the *Movimento Sanitário* in Brazil, the National Movement for the Defense of the Right to Health in Paraguay, the Right to Health and Health Care Campaign in India, and the global People's Health Movement (see Turiano

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and Smith 2008). The healthcare justice movement is not homogeneous, since many health-related needs and deprivations are dependent on context and constituency, but the overall aim is to prioritize the needs of the global poor. In South Africa, for example, TAC adopted a successful strategy of pursuing claims for access to adequate medical treatment and essential medicines, including public antiretroviral provision for poor people living with HIV/AIDS, through a combination of rights-based public interest litigation and political mobilization "led by people with HIV" so as to construct a non-stigmatized status and thereby resist their sociocultural subordination and disrespect (Heywood 2009: 17). Along these lines, Pogge (2010: 21) notes that the patent protectionism enforced by the WTO's multilateral Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) inflates the prices of essential medicines, discourages R&D for "unprofitable" diseases that mainly affect developing countries, and further entrenches global health inequalities by curtailing the access of poor people to more affordable generic versions of brand-name pharmaceuticals. The point to stress is that activism for health equity involves empowering disadvantaged individuals and groups to have a voice in raising public awareness about social disparities in health, to be advocates for their own priority health needs, and to act as participants in the political struggle for recognition of their status as equal rights-holders.

Conclusion

The human right to health entails ethical claims about vital human interests, legal measures establishing a set of interrelated entitlements, and political actions intended to prevent harm and improve lives. The normative ideal of the highest attainable standard of health ensured for all may be ambitious, but it is based on the urgent vision that access to (p. 367) adequate health services and essential medicines is a requisite not merely for life but for a properly human life of meaningful dignity, wellbeing, and functioning. This chapter has examined the centrality of health to human wellbeing and the institutional insertion of the question of health within the international human rights framework. Here the right to health is, to use Shue's expression, a "basic right." Basic rights bring with them demands for the mitigation and progressive rectification of global health inequalities and unequal distributions of the social determinants of health, which disproportionately affect those living in poverty. But beyond matters of material deprivation and problems of economic redistribution, my aim has been to show that a deeper engagement with the right to health reveals how poverty and inequality are bound up with discriminatory attitudes, lack of respect, and non-inclusive subordination. Misrecognition contributes to systemic disavowal of the social determinants of health and thus to the fates of those living (or dying) under the grossly unequal burden of ill health. Health inequalities arise from the ways that inequalities in power, resources, and status, both within and between countries, condition the ability of different individuals and

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groups to access adequate health care and essential medicines, and to live at least reasonably healthy and therefore properly human lives.

I have argued that, seen in this light, the human right to health is best conceived not as an inherent pre-political right but as a political claim emerging from struggles for equal recognition in contexts of inequality and deprivation on the part of those most vulnerable to health disparities. This argument has sought to illustrate several distinctive contributions that a critical recognition perspective makes to fostering the conditions necessary for the highest attainable standard of health and wellbeing for everyone: empowering the poor to hold governments accountable for health inequalities; creating opportunities for public inclusion in developing policies and programmes that are consistent with human wellbeing; providing a framework for redress of rights violations and social exclusion; and mobilizing civil society action to achieve acknowledgement of the right to health. Yet undeniable tensions remain in the international domain between contending statist and globalist definitions, priorities, and processes of health security and human rights. Likewise, addressing preventable and unwarranted disparities in health status that reinforce the poor’s lack of power and voice is, for international political theorists, a principal challenge going forward. This situation reveals that the meaning and practical reality of the human right to health is still in flux. In short, the intersection of poverty and health continues to be a multifaceted, complex, and far-reaching human rights issue of the first importance.

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Patrick Hayden

Patrick Hayden is Professor of Political Theory and International Relations in the School of International Relations at the University of St Andrews.

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