

Human rights are the wrong basis for healthcare

By William Easterly

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The agonising [US healthcare debate](#) has taken on a new moral tone. President Barack Obama recently held a conference call with religious leaders in which he called healthcare “a core ethical and moral obligation”. Even Sarah Palin felt obliged to concede: “Each of us knows that we have an obligation to care for the old, the young and the sick.”

This moral turn echoes an international debate about the “right to health”. Yet the global campaign to equalise access to healthcare has had a surprising result: it has made global healthcare *more* unequal.

The notion of a “right to health” has its origins in the United Nations’ Universal Declaration of Human Rights in 1948. But in the decades that followed, foreign aid’s most successful efforts in health – such as the World Health Organisation and Unicef campaigns on vaccines and antibiotics – were based on a more limited goal: obtaining the largest possible health benefits for the poor from finite foreign aid budgets.

The moral argument made a big comeback in the new millennium. One of its most eloquent advocates is Dr Paul Farmer, who earned fame with heroic efforts to give people access even to complex medical treatment amid extreme poverty in Haiti and Rwanda, saying that healthcare was “a fundamental human right, which should be available free”. The WHO shifted from pragmatic improvement of health outcomes towards “the universal realisation of the right to health”. Even [Amnesty International](#), advocate of traditional human rights such as freedom from torture, added a new section to its human rights report in 2009 on the “right to health”.

So what is the problem? It is impossible for everyone immediately to attain the “highest attainable standard” of health (as the health rights declaration puts it). So which “rights to health” are realised is a political battle. Political reality is that such a “right” is a trump card to get more resources – and it is rarely the poor who play it most effectively.

The biggest victory of the “right to health” movement has been the provision of aid-financed antiretroviral treatment for African Aids patients, who include the upper and middle classes. Aids treatment got funding from, among many others, the Bush and Obama administrations, the Clinton Foundation, the Gates Foundation and the UN Millennium Development Goals campaign. The WHO 2004 report that emphasised the “right to health” did so on behalf of only one specific effort – Aids treatment.

Saving lives in this way is a great cause – except to the extent that it takes resources away from other diseases. Alas, many observers fear that is exactly what it did.

An evaluation by the World Bank in 2009 faulted the bank for allowing Aids treatment to drive out many other programmes. Global deaths due to either tuberculosis or malaria stood at 2m in 2008, around the same as those from Aids. Yet Aids accounted for 57 per cent of World Bank projects on communicable diseases from 1997 to 2006, compared with 3 per cent for malaria and 2 per cent for TB. Other big killers of the poor – such as pneumonia, measles and diarrhoeal diseases, which together accounted for more than 5m deaths in 2008 – received even less attention.

Rights advocacy also favours some aspects of health relative to others. Those who are HIV-positive advocate effectively for their right to treatment, while those who will get Aids in the future cannot organise a lobby for a “right to prevention”. The results can be seen in the 2009 report of the [President’s Emergency Plan for Aids Relief](#) (Pepfar), one of the largest foreign aid programmes in American history. Only 22 per cent of its budget goes towards prevention, compared with 48 per cent towards treatment.

The lesson is that, while we can never be certain, the “right to health” may have cost more lives than it saved. The pragmatic approach – directing public resources to where they have the most health benefits for a given cost – historically achieved far more than the moral approach.

In the US and other rich countries, a “right to health” is a claim on funds that has no natural limit, since any of us could get healthier with more care. We should learn from the international experience that this “right” skews public resources towards the most politically effective advocates, who will seldom be the neediest.

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