GLOBAL HEALTH CARE INJUSTICE: AN ANALYSIS OF THE DEMANDS OF THE BASIC RIGHT TO HEALTH CARE

By

PETER GEORGE NEGUS WEST-ORAM

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Department of Philosophy

School of Philosophy, Theology and Religion

College of Arts and Law

University of Birmingham

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ABSTRACT

Henry Shue's model of basic rights and their correlative duties provides an excellent framework for analysing the requirements of global distributive justice, and for theorising about the minimum acceptable standards of human entitlement and wellbeing. Shue bases his model on the claim that certain 'basic' rights are of universal instrumental value, and are necessary for the enjoyment of any other rights, and of any 'decent life'. Shue's model provides a comprehensive argument about the importance of certain fundamental goods for all human lives, though he does not consider health or health care in any significant detail. Adopting Shue's model, I argue that access to health care is of sufficient importance to the enjoyment of any other rights that it qualifies as what Shue describes as a 'basic' right. I also argue that the basic right to health care is compatible with the basic rights model, and is required by it in order to for it to achieve its goal of enabling right holders to enjoy any decent life. In making this claim I also explore the requirements of the basic right to health care in terms of Shue's triumvirate of duties and with reference to several key examples.

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Contents

GLOBAL JUSTICE AND THE BASIC RIGHT TO HEALTH CARE

PREFACE

In this thesis I argue that access to basic health care is a necessary requirement of the enjoyment of all other rights. Consequently, I argue that such access must be acknowledged as the ‘substance’ of a right (Shue 1996, p.15), to which all persons are entitled. Further, I argue that such is the importance of access to health care, it qualifies as what Henry Shue has described as a ‘basic right’ (1996, p.18). To make this claim I adopt Shue’s basic rights model, which identifies three categories of basic right, to security (Shue 1996, p.20), subsistence (Shue 1996, p.22), and liberty (Shue 1996, p.65), and argue that an additional basic right to health care is compatible with the model, and is required by it in order to meet its goal of guaranteeing right holders the ability to enjoy all other rights.

Henry Shue states that his primary goal for the basic rights model is to ‘rescue from systematic neglect within wealthy North Atlantic nations a kind of right that...deserves as much priority as any right: rights to subsistence’ (1996, p.65). My goal for this thesis is inspired by this aim, and seeks to achieve a similar outcome for the right to health care by highlighting the importance of the right and defining its requirements. This is not to suggest that Shue neglects the importance of health care rights to nearly the extent that subsistence rights have been neglected. Indeed, Shue does acknowledge entitlements to ‘minimal preventative public health care’ (1996, p.23) as a subsidiary aspect of the basic right to subsistence. However, he does not consider the requirements of a right to health care in depth, and as I argue in chapters one and five, health care is of sufficient importance and complexity to qualify as a distinct basic right in its own regard.[1]

To achieve these goals I make three main arguments; first, that the basic rights model proposed by Shue provides an effective way of theorising about global justice, but that it does not consider in sufficient detail the health care requirements of achieving its goal of enabling the enjoyment of all rights. Second, that health care is vital for the enjoyment of all other rights as rights, and thus qualifies as the substance of a distinct basic right. Third, that the basic right to health care is compatible with the basic rights model, and is required by the model in order to achieve its goal of enabling right holders to enjoy any decent life. In making these claims I also explore the requirements of the basic right to health care in terms of Shue's triumvirate of duties and with reference to several key examples.

This thesis is structured as follows; in chapter one I provide an overview of the basic rights model, argue for the importance of a basic right to health care in more detail and argue that the basic rights model, and especially its triumvirate of duties, provides an effective and appropriate method for theorising about global health care justice. In chapter two I explore the requirements of the first of Shue's three duties, the duty to avoid depriving, with reference to global intellectual property law in the pharmaceutical industry. I argue that current patent law avoidably deprives many of access to

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[1] I also argue that acknowledging health care as the substance of a distinct basic right allows for more accurate theorising about the implications and requirements of the right.

essential medicines, to which they are entitled under the basic right to health care, and that this violates the duty to avoid depriving. In doing so I set out what the duty to avoid depriving requires of duty bearers, and how this applies to the basic right to health care generally.

In chapter three I discuss the duty to protect from deprivation, the second of Shue’s three duties, with reference to the problems presented for public and individual health caused by infectious disease. In doing so, I argue that the duty entails three types of protective intervention, the provision of each of which is necessary to fulfil the demands of the duty to protect from deprivation, and which collectively serve to provide protection against deprivations of health. I also examine how responsibility for providing these interventions can be assigned to appropriate duty bearers. In chapter four I examine the last of Shue’s duties, the duty to aid the deprived, and propose a set of five criteria for evaluating real and potential deprivation and aid scenarios for the purpose of priority setting for resource allocation. These criteria can also be used to define the requirements of the duties to protect from deprivation and to aid the deprived, and to set limits on the obligations which can be imposed on duty bearers by either duty.[1] In chapter five I consider four categories of objection to my argument for a basic right to health care and provide brief responses to each. Finally, in chapter six, I conclude with a restatement of my argument in this thesis.

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[1] In discussing each of these duties I demonstrate how different deprivations of health can make it impossible for right holders to ‘actually enjoy’ the substances of their rights (Shue 1996, p.13).

As noted above, this is a thesis largely about justifying and explaining a basic right to health care and its requirements. As such, the work that follows includes consideration of questions of public health, intrapersonal obligations, and the demands of justice. In addition, the focus of this thesis is unavoidably global, since in an interconnected world, health and disease are questions of global concern. Therefore, while the principles proposed in this thesis are applicable to questions of domestic, or internal, health justice, they should be seen as responding to larger questions of global inequality and deprivation. In this way, the thesis can be seen as an attempt to contribute, in however small a fashion, to defining ‘where decent life starts’ (Shue 1996, p.xi) and to show that access to health care is an essential component of ensuring that all persons achieve at least this threshold.

CHAPTER ONE

GLOBAL JUSTICE AND THE BASIC RIGHT TO HEALTH CARE

> *In this chapter I argue that health care is of sufficient importance to the enjoyment of other rights that it qualifies as what Henry Shue describes as the substance of a basic right. I also argue for the utility of Shue's basic rights model as a framework for theorising about global justice. In doing so, I describe the key points of Shue's model, explain his definitions of basic and non-basic moral rights, and examine the rights which he considers to be basic. Having done so, I explain the structure of the rest of the thesis.*

Henry Shue's model of basic rights provides one way of thinking about certain fundamental goods, the enjoyment of which are argued to be essential for enjoyment of any other rights, and any 'decent life' (1996, p.xi). In this thesis I argue that health care is of sufficient importance that it qualifies as the substance of a distinct basic right under Shue's model. My goal in this thesis is to demonstrate that the right to health care qualifies as a basic right, and is compatible with Shue's original formulation of the basic rights model. In doing so, I explore the requirements of this additional basic right, focusing on the health care specific demands of Shue's triumvirate of duties (Shue 1980, p.60).

In this chapter I provide an overview of Shue's model of basic rights, before arguing that an additional basic right to health care is compatible with the model, and is necessary for achieving Shue's stated aim of providing 'some minimal protection against utter helplessness to those too weak to protect themselves' (1996, p.18). To achieve this goal I first set out Shue's explanation of the purpose of moral rights. Second, I explain Shue's definition of moral rights in general, and set out how basic rights are differentiated from non-basic rights. Third, I explain what Shue means by 'standard threats' (1996, p.29). Fourth, I set out the features of the three rights which Shue defines as basic, and describe how each qualifies as a basic right. Fifth, I argue that health care should be recognised as the substance of a basic right in its own regard. Sixth, I argue that the right with which I am concerned in this thesis is a right to health care and not health. Seventh, I discuss the implications of Shue's rejection of the distinction between positive and negative rights. Eighth, I provide an outline of Shue's system of duties correlating to each of the basic rights.[1] Ninth, I discuss three advantages of Shue's model of basic rights as a method of theorising about global health care justice with reference to alternative models.

1.1 – The Purpose of Moral Rights

In this section I outline Shue's explanation of the purpose of moral rights, which he argues is to protect right holders from irresistible hazards, and protect human dignity. According to Shue, moral rights provide right holders with protection against harms that they would otherwise be powerless to

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[1] Each of these duties is the subject of an individual chapter later in the thesis, where I discuss the specific requirements of each duty in the context of the basic right to health care.

prevent or avoid. Basic rights, the special category of moral rights with which Shue is primarily concerned, are referred to as the ‘morality of the depths’ which ‘specify the line beneath which no one is to be allowed to sink’ (Shue 1996, p.18). As such, Shue argues, they are the minimum morally acceptable set of entitlements owed to right holders. According to Shue, they are the prerequisites for the enjoyment of any and all other rights, and are therefore essential for any decent life. Citing Nietzsche’s analysis of morality as a constraint upon the powerful (Nietzsche 2010), Shue argues that one of the chief goals of morality is to ‘provide some minimal protection against utter helplessness to those too weak to protect themselves. Basic rights are a shield for the defenceless’ (1996, p.18). They are intended, according to Shue, to protect right holders from deprivations which would leave them ‘at the mercy of others’ (1996, p.30), and to provide the vulnerable with the means to resist powers against which they would otherwise be helpless.

For this reason, Shue argues that rights are closely tied to human dignity, since they provide all persons with the ability and authority to assert their moral status as human beings by ‘mak[ing] demands of others’ (1996, p.13). Shue also cites Joel Feinberg and argues that in providing right holders with ‘the rational basis…for a justified demand’ (Shue 1996, p.13), rights assert the moral status of right holders by empowering them as ‘inherently deserving’ or ‘dignified objects of respect’ rather than as ‘lucky’ beneficiaries of charity or ‘noblesse oblige’ (Feinberg 1973, pp.58–59) cited in (Shue 1996, p.15). The power to make demands of others is, according to Shue, the power to demand, and to have acknowledged, recognition of one’s moral status.[1] Basic rights therefore have two aims, to guarantee right holders at least what Gillian Brock describes as a ‘minimally decent life’ (2009, p.13), and to support human dignity. In making this argument, Shue claims that basic rights are so important that all persons have reason to value them, and that the denial of basic rights is something which ‘no self-respecting person can reasonably be expected to accept’ (1996, p.19).

1.2 – Defining Moral Rights

In this section I explain Shue’s definition of moral rights. The term ‘moral right[s]’ (Shue 1996, p.13) refers to rights in general, basic rights are a special sub-type of moral rights. As such, the features discussed in this section are also features of the basic rights.[2] According to Shue, all moral rights provide ‘(1) the rational basis for a justified demand (2) that the actual enjoyment of a substance be (3) socially guaranteed against standard threats’ (1996, p.13).[3] Therefore, to have a right is to have an entitlement to a specific good, which must be guaranteed by other persons. As such, if a person has a right to X, they are entitled to expect that other people will guarantee (to a reasonable extent, as I discuss below) that they are able to actually enjoy X. This definition can be used to provide three criteria which all potential or

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[1] Jonathan Wolff has similarly stated that rights ‘give permanence and power’ (2012, p.16) to right holders in a way that charity, kindness or ‘noblesse oblige’ (Feinberg 1973, pp.58–59) cited in (Shue 1996, p.15) do not.

[2] I set out what distinguishes basic rights from non-basic moral rights in the following section.

[3] Shue defines the substance of a right as ‘whatever the right is a right to’ (1996, p.15).

suggested rights must fulfil in order to qualify as moral rights.[1] In this section, I explain these criteria in turn, starting with what I shall describe as the 'justified demands' criterion.

The first aspect of Shue's definition of rights means that an actual right is supported by 'general principles that are good reasons why one's demands ought to be granted' (Shue 1996, p.13). Shue does not provide an account of what would count as a 'rational basis or an adequate justification' (1996, p.13), and acknowledges the difficulty of providing such an account (1996, p.13).[2] However, he does, in the course of *Basic Rights* (1996), offer a set of principles which would count as the 'rational basis or an adequate justification' (1996, p.13) of the basic rights, as I discuss in the following section. In the meantime, it is enough to state merely that in order to qualify as an actual moral right, candidate rights must be supported by 'general principles that are good reason why one's demands ought to be granted' (Shue 1996, p.13). If a candidate right is not supported by adequately good principles there may still be a legally supported entitlement to the substance of that right, yet it will not be an actual moral right in the sense Shue means. Therefore, in order to qualify as an actual moral right, a candidate right must

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[1] I shall use the terms 'actual moral rights' and 'quasi moral rights' to differentiate between those moral rights which fulfil each of these criteria, and those 'right-like' statements which may appear to do so, but which fail to fulfil at least one aspect of Shue's definition. I also use the term 'candidate moral right' to refer to those 'rights', the status of which (as actual or quasi rights) is initially unclear.

[2] I also do not attempt to provide such a general account, instead, I aim only to provide an argument for what would count as a 'rational basis' for the basic right to health care (1996, p.13). I discuss this 'rational basis' in section six of this chapter.

be supported by reasons good enough to justify the claims. I term this requirement the ‘justified demands’ criterion.

The second part of Shue’s definition requires that actual-moral rights refer to the ‘actual enjoyment of a substance [of the right]’ (1996, p.13). That is, if a candidate moral right is to be described accurately as an actual moral right, it must actually entitle right holders to the substance to which the right refers. For example, a candidate moral right to education must actually entitle right holders to education if it is to count as an actual moral right to education. It is not enough to count as an actual-moral right to education that it guarantee only promises to education, or the existence of an open market in education services in which right holders are not formally prohibited from participating (Shue 1996, p.15).[1] To have a right to education is to be entitled to the actual enjoyment of education services. For a candidate moral right to qualify as an actual moral right to a given substance, it must refer, and entitle right holders, to the actual enjoyment of that substance.

An important consequence of this part of the definition of moral rights, which I shall term the ‘actual enjoyment’ criterion, is that rights entitle right holders not only to the thing to which they are rights (the right’s substance), but also to the things essential for the enjoyment of that substance. This feature of the actual enjoyment criterion is fundamental to Shue’s explanation

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[1] However, such entitlements may be the objects of actual moral rights, but they would be rights to ‘promises-of-the-provision-of-education’, or to ‘open-markets-in education’, and not to education itself. That is, if a right guarantees enjoyment of X, it is a right to X, if it guarantees only a promise of enjoyment of X, then it is not a right to X, but to ‘promises-of-enjoyment-of-X’.

of what makes certain rights basic (1996, p.31), and I shall discuss it in more detail in the following section. For example, in explaining the basic right to security, Shue argues that '[n]o one can fully enjoy any right that is supposedly protected by society if someone can credibly threaten him or her with murder, rape, beating etc., when he or she tries to enjoy the alleged right' (1996, p.21). Therefore, Shue argues, the acknowledgement of any right also implicitly acknowledges a right to security. Therefore, the actual enjoyment criterion implies that right holders are also entitled to those things necessary for the actual enjoyment of the substances of their first right, and is the basis for the distinguishing feature of the basic rights.

Shue states that the third aspect of his definition is 'probably the single most important aspect of a standard right, because it is the aspect that necessitates correlative duties' (1996, p.16). I use the term 'social guarantees' criterion to refer to this part of Shue's definition of moral rights. This aspect of Shue's definition of moral rights means that in order to qualify as an actual moral right, candidate moral rights must entail duties to provide social guarantees against deprivations of the substances of rights. In this context, social guarantees are the product of duties, which are owed by duty bearers to right holders, and are the means by which rights are guaranteed, and duties discharged. This aspect of Shue's definition of moral rights is the requirement that 'some other people make some arrangements so that one will still be able to enjoy the substance of the right even if – actually, *especially* if – it is not within one's own power to arrange on one's own to enjoy the substance of the right' (1996, p.16). If a candidate moral right entails no such duties, it does not qualify as an actual moral right since it offers no mechanism to guarantee the actual enjoyment of the right's substance. As such, status as a moral right is contingent upon the candidate right in question entailing correlative duties.[1] Importantly, Shue notes that this aspect of the definition of moral rights does not require that it is 'impossible for anyone to be deprived of [the substances of their rights] or only if no one is ever deprived of [the substances of their rights]' (Shue 1996, p.17). Instead, this aspect of the definition requires only the provision of 'some reasonable level of guarantee' against what Shue later describes as the 'standard threats' to wellbeing (1996, p.17). I explain what Shue means by 'standard threats' in more detail in section 1.4.

I suggest the following terms for each of these three parts of the definition of moral rights, and use them in the remainder of this chapter.

1) *Justified Demands* - Rights provide reasons good enough to justify right holders making demands for the things to which they have rights. They empower right holders to 'make demands of others' (Shue 1996, p.13).
2) *Actual Enjoyment* - Rights entitle right holders to the enjoyment of the actual thing to which they have a right – they do not refer to

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[1] It is worth noting that even if right holders are able to enjoy the substance of the right, in the absence of a social guarantee of entitlement, the substance is not enjoyed by right, but merely as a result of contingent circumstance. Correlatively, if duties are asserted by an actual moral right, but are not fulfilled, this does not necessarily mean there is no right, but may merely mean that it is being denied, though the effect may be the same.

statements endorsing rights, or to promises that enjoyment will be provided in the future.

3) *Social Guarantees* – Rights provide right holders with the entitlement to expect that some other person or persons will ensure that they are able to access the substances of their rights even if right holders are unable to provide them for themselves. This is the requirement that entails the existence of correlative duties, and is the most important, according to Shue, of the three features discussed in this section.

Collectively, these three criteria define moral rights. As such, for a candidate moral right to qualify as an actual moral right it must be supported by good reasons, refer to the actual enjoyment of the substance of the right it asserts, and must entail duties on the part of other persons. If a candidate moral right does not fulfil any one of these criteria, it does not qualify as an actual moral right. In the following section I set out what differentiates the basic rights described by Shue from other types of moral right.

1.3 – Defining Basic Rights

In the previous section I set out Shue's definition of the features of all moral rights. This category includes the rights defined by Shue as 'basic', though as I explain in this section, basic rights are importantly different from other, non-basic, moral rights. In this section I first set out Shue's explanation of what differentiates basic from non-basic rights, before explaining the three important consequences, identified by Shue, of his definition of basic rights. I conclude this section with a summary of the defining criteria of basic rights.

First, Shue identifies one unique feature of basic rights which distinguishes them from non-basic rights – their necessity for the enjoyment of all other rights. Rights are basic according to Shue when ‘enjoyment of them is essential to the enjoyment of all other rights. This is what is distinctive about a basic right’ (1996, p.19). Put differently, basic rights are the prerequisites, or necessary conditions, of enjoyment of any and all other rights. Importantly, Shue’s definition of ‘necessary’ in this context is extremely narrow, and does not refer to things which ‘would be convenient or useful, but only what is indispensable to anything else’s being enjoyed as a right’ (1996, p.31). ‘Necessary’, is taken by Shue to mean ‘“made essential by the very concept of a right”’ (1996, p.31). The necessity of the basic rights also means that they are mutually dependent, since enjoyment of each basic right is necessary for enjoyment of each of the others (Shue 1996, p.70).

The requirement that a right be essential for all other rights in order to qualify as a basic right is claimed by Shue to mean that the list of basic rights is ‘quite short’ (1996, p.29). This is because many rights, though intrinsically valuable, are not necessary for the enjoyment of all other rights. For example, he excludes education from consideration as a basic right because while education is ‘greater and richer’ than some basic rights (1996, p.20), it is possible to enjoy other rights in the absence of a right to education. Further, Shue claims that the basic rights are not necessarily more intrinsically valuable than non-basic rights, since status as a basic right is derived solely from the instrumental value of the right in question. For example, he asserts that security is a basic right because it is not possible to enjoy other rights as rights (i.e. as something which meets the three criteria discussed in the previous section) in the absence of a right to security (Shue 1996, p.22).

Second, this ‘necessity condition’ of basic rights has three important implications; first, Shue argues that fulfilment of the basic rights must take priority over fulfilment of non-basic moral rights. Second, because of their status as the prerequisites of all other moral rights, basic rights describe the minimum morally acceptable set of entitlements owed to all right holders. Third, basic rights are necessary for all life plans and are compatible with all views of the good. As such, Shue argues that they are universally desirable. These conditions are closely related, and occur as a consequence of the status of basic rights as necessary conditions for all other rights. As such, fulfilment of the necessity condition remains the only requirement that rights must meet in order to qualify as basic. However, as inevitable consequences of the necessity condition, these features always apply to basic rights and as such it is worth briefly explaining them here, because doing so helps to clarify the nature of basic rights, and their importance. In addition, as I discuss in section 1.9 these features of the necessity condition have important implications for the nature of the duties corresponding to basic rights.

Shue argues that the first consequence of the necessity criterion is that if one were to assert any other right, to education for example, one would also implicitly be asserting the existence of the basic rights, since these latter rights are the prerequisites of the former. Therefore, fulfilment of basic rights cannot be sacrificed in favour of fulfilment of non-basic rights ‘because it cannot be sacrificed successfully. If the right sacrificed is indeed basic, then no right for which it might be sacrificed can actually be enjoyed in the absence of the basic right. The sacrifice would have proven self defeating’ (1996, p.19).[1] As a consequence, fulfilment of the basic rights must take priority over fulfilment of non-basic rights, since the former are the necessary conditions of the latter.

The second consequence of the necessity criterion is that Shue describes basic rights as ‘the morality of the depths’ which ‘specify the line beneath which no one is to be allowed to sink (Shue 1996, p.18). Basic rights have this status because they describe what is minimally necessary for the enjoyment of all other rights and any decent life. Therefore, if one endorses *any* other rights, one must also acknowledge that all persons are entitled to *at least* the basic rights. Basic rights, according to Shue, describe the minimum threshold of human welfare, and provide right holders with guarantees to the things needed to live a ‘decent life’ (1996, p.xi). As such, Shue argues, they are closely related to self respect and human dignity in a similar manner to Feinberg’s discussion of claim rights mentioned above. This is because, in guaranteeing right holders access to at least a bare minimum set of goods, they assert the moral status of all right holders.

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[1] In a sense this would violate the ‘universal law’ formulation of the categorical imperative (Kant 1998, p.AK 4: 421).

Related to this condition, the third consequence of the necessity criterion is that the basic rights are compatible with any rational view of the good, are necessary for any life plan, and as such are universally desirable. Basic rights Shue states are ‘the rational basis for justified demands the denial of which no self-respecting person can reasonably be expected to accept’ (1996, p.19). That is, while other rights may plausibly be rejected by some rational agents, basic rights will be desired, according to Shue, by all rational persons. The reason that denial of any basic right would be unacceptable to ‘any self-respecting person’ is, following the ‘priority condition’ I described above, because such denials would render enjoyment of any other rights, and thereby life plan, impossible (Shue 1996, p.19).[1]

These three consequences of the necessity condition do not define basic rights in the same way as the necessity condition because they exist only as a consequence of that defining characteristic of the basic rights. However, given their inevitable association with the necessity condition and with basic rights, it is worth explaining them here since they help define the necessity condition, and highlight the importance of the basic rights. In the remainder of this section, I set out the full list of characteristics by which basic rights are defined.

Firstly, because basic rights are moral rights, the three criteria discussed in the previous section all apply to the basic rights. Therefore, basic rights

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[1] I expand on this claim in more detail in chapter five, when I argue for the compatibility of the basic right to health care with all cultural paradigms.

provide '(1) the rational basis for a justified demand (2) that the actual enjoyment of a substance be (3) socially guaranteed against standard threats' (Shue 1996, p.13). Secondly, basic rights are necessary for the enjoyment of all other rights (including the other basic rights). It is for this reason that the basic rights fulfil the *justified demands* condition – because basic rights are necessary for the enjoyment of all other rights and of any decent life, and are therefore key to respecting human dignity, there are exceptionally good reasons to guarantee them. In addition, and as noted above, denial of the basic rights is, according to Shue, something which no 'self-respecting person can reasonably be expected to accept' adding force to the justification for the basic rights (1996, p.19). There are also three important consequences of the necessity condition; first, fulfilment of the basic rights must take priority over fulfilment of non-basic rights. Second, basic rights describe the minimum morally acceptable set of entitlements owed to right holders. Third, basic rights are universally desirable. These four criteria, and the three consequences of the necessity condition, can be summarised as follows;

1) *Justified Demands* – As above.
2) *Actual Enjoyment* – As above.
3) *Socially Guaranteed* – As above.
4) *Necessity* - Rights which are basic are essential for the enjoyment of all other rights, including other basic rights. This means that enjoyment of all rights (including all basic rights) is dependent upon fulfilment of all other basic rights. This has the following three consequences.

a. *Priority* – fulfilment of the basic rights must take priority over fulfilment of non-basic rights.
b. *Minimum Standard* – the basic rights collectively describe the absolute minimum standard of entitlements owed to right holders.
c. *Universal Application* – basic rights are necessary for, and compatible with, all life plans.

Shue identifies three rights which meet the necessity condition described above, and which therefore qualify as basic rights; rights to security (1996, p.20), subsistence (1996, p.22), and to liberty (1996, p.60). In section 1.5 I set out Shue's account of these rights, and explain how they qualify as basic rights. First, however, in the following section I explain an important caveat contained with the *social guarantees* condition of moral rights, the requirement to guarantee against only 'standard threats' (Shue 1996, p.13).

1.4 – Defining Standard Threats

In this section I explain the impacts of one of the most important aspects of Shue's definition of moral rights - that they provide guarantees only against what Shue describes as 'standard threats' (1996, p.13). This caveat is important for the definition of moral rights, and is included by Shue in order to avoid 'utopian...guarantees against every conceivable threat' (1996, p.32), and the proliferation of basic rights.[1] Rights, according to Shue, provide only reasonable and 'realistic' (1996, p.33) guarantees, hence the restriction of the

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[1] I discussed the narrowness of Shue's definition of 'necessary' in the previous section.

social guarantees condition to providing protection against ‘standard threats’ (1996, p.13). In this section, I explain in more detail how the standard threats caveat limits the extent of the duties required by moral rights, and ensures they remain context aware.

First then, Shue defines standard threats as ‘common, or ordinary, and serious but remediable threats’ (1996, p.32). Rights therefore do not, according to Shue, provide guarantees against all threats of deprivation, only against those which fit this definition. Further, Shue states that ‘the measure of successful prevention of thwarting [of enjoyment of the basic rights] by ordinary and serious but remediable threats is not utopian. People are neither entitled to social guarantees against every conceivable threat, nor entitled to guarantees against ineradicable threats like eventual sickness, accident, or death’ (1996, p.32). As such, fulfilment of the basic rights does not require that no-one ever become seriously ill or be the victim of violent attack (Shue 1996, pp.17, 23, 25).

Secondly, it is not possible, nor always necessary, to respond to all potential deprivations, but it is possible and realistic to emplace systems which minimise the likelihood that standard threats will inflict deprivations on right holders. For example, while it is unlikely to be possible to prevent all instances of accidental injury, effective social policies can minimise the frequency with which they do occur (Makowsky & Stratmann 2011, pp.863–865). Similarly, Shue suggests that ‘we may have very little excuse for allowing so many poor people to die of malaria and more excuse probably for allowing people to die of cancer' because of the limits of existing medical technology, and the respective costs associated with achieving either aim (1996, p.33). However, Shue notes that given the possibility of medical development, we may later have 'equally little excuse to allow deaths by many kinds of cancer' (Shue 1996, p.33). The moral demands of the basic rights are therefore at least partially contingent upon the context in which they exist. I discuss the issue of determining what would qualify as a reasonable demand in more detail in chapter four, when I propose a set of criteria for evaluating the demands of the duty to aid the deprived.

Finally, the basic rights described by Shue are likely to offer greater protections and entitlements than may currently be enjoyed by many right holders, and more than may be assumed by those endorsing a 'negative only' approach to rights. However, as discussed in this section, they do not provide right holders with unlimited entitlements, nor perfect guarantees of protection. Instead the basic rights provide right holders with reasonable and realistic guarantees of protection against those hazards which 'could ordinarily be expected to prevent, or hinder to a major degree, the enjoyment [of other rights]' (Shue 1996, p.32). This guarantee is limited further by Shue's acknowledging the limits of medical technology, and of resource constraints, though as he notes 'what is reasonable can change' (1996, p.33).

In the following section I provide a brief overview of the three rights Shue describes as basic, before explaining each right in turn, its requirements, and how it qualifies as a basic right.

1.5 – Shue's Three Basic Rights

In this section I briefly describe the basic rights described by Shue and explain how they qualify as basic rights. As noted above, Shue mentions three categories of basic right which meet the necessity criterion; to security (1996, p.20), subsistence (1996, p.22), and to liberty (1996, p.60).[1] According to Shue, these three basic rights each include a set of subsidiary rights, and are collectively the necessary conditions for the enjoyment of all other rights.[2] In the following sections I discuss each right in more detail, and explain the requirements of each right and how each qualifies as a basic right.

1.5a – The Basic Right to Security

In this section I explain how the first of Shue's basic rights qualifies as such by fulfilling both the necessity condition and the three aspects of Shue's definition of moral rights. I also briefly mention some of the requirements of the basic right to security. I begin by explaining how security fulfils the necessity condition, since doing so demonstrates how the right also fulfils the justified demands condition.

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[1] Shue notes however, that he does not think that the three basic rights he describes are the only basic rights (Shue 1996, p.157).

[2] These basic rights therefore qualify as what Judith Jarvis Thomson describes as 'cluster rights', in that they all refer to a collection of subsidiary rights, which collectively serve to promote and protect one specific good, such as security or liberty (1992, pp.55–56). While the basic rights described by Shue do qualify as cluster rights, this is not part of Shue's original definition, and would not qualify a right as basic in its own regard. However, as I argue in chapter five, the status of the basic right to health care as a cluster right does provide an additional argument for grouping it with the other basic rights for purposes of clarity.

Firstly, according to Shue, security provides the safe context in which other rights may be enjoyed. Shue argues that in the absence of physical security, violence or the threat of it can be used to prevent right holders from enjoying the substances of their other rights (Shue 1996, p.30). For example, as noted above, if one cannot attend school without fear of violent interference (in the absence of a guarantee of physical security) one is not able to actually enjoy the right to education since access to it has not been socially guaranteed (Geissinger 1997, pp.428–430; Polisi 2004, pp.41–42). As such, one might be said to lack any such right at all. As a result, protection from the violence of others is seen by Shue as essential for the enjoyment of all other rights and of any decent life, and to therefore qualify as the substance of a basic right. Therefore, a right to security fulfils the necessity condition, and as a consequence, also provides good reasons which justify demands on others that security be socially guaranteed. This is because in the absence of a right to security, the threat or use of violence can be used to prevent the enjoyment of any other rights, or any decent life. According to Shue, one cannot enjoy any decent life if one is not physically secure (1996, p.30).

The second aspect of Shue's definition of moral rights means that rights make demands about the substance of the right, not about promises about that substance, or about the mere absence of deliberate obstruction of one's attempts to achieve the substance. The basic right to security therefore demands that right holders not be subjected to 'murder, torture, mayhem, rape, or assault' (Shue 1996, p.20). This is not a demand that duty bearers promise not to commit such acts; it is a demand that duty bearers actually refrain from performing those acts, and that someone will ensure that protection is provided against their occurrence. Further, the basic right to security is not a right to have available for purchase (or for some other method of personal acquisition) the means to guarantee one's physical safety. The basic right to security is a right to enjoy the state of being physically secure. As such, the actual enjoyment aspect of Shue's definition entails the provision of social guarantees, as I discuss below.

Thirdly, as a moral right, the basic right to security entails the existence of duties to provide 'social guarantees against standard threats' to the enjoyment of physical security (Shue 1996, p.13). In order to ensure the actual enjoyment of physical security, Shue argues that significant positive actions must be undertaken by duty bearers because while 'it may be possible *to avoid violating* someone's rights to physical security yourself by refraining...it is impossible *to protect* anyone's rights to physical security without taking, or making payments towards the taking of, a wide range of positive actions' (1996, p.37) (italics in original). Accordingly, Shue argues that the right entails duties to provide protection to right holders, in addition to obligations not to cause harm in order to ensure that rights are not curtailed by the violence of the unscrupulous.[1] According to Shue, the institutions required to guarantee the actual enjoyment of physical security

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[1] Though Shue notes that excessive emphasis on protective systems carries the risk that they could be used to oppress, or to deny rights to security rights themselves (1996, p.61). As such, the basic right to security demands both positive and active obligations from duty bearers.

may include things like ‘police forces; criminal courts [and] penitentiaries’ (1996, p.37).

Finally, security qualifies as the substance of a basic right because in its absence the threat or use of violence can be used to deprive right holders of the ability to enjoy any other rights or enjoy a decent life. As a result, the demand for the actual enjoyment of security is supported by extremely good reasons which justify the existence of the right. Further, in order to ensure the actual enjoyment of the substance ‘security’, the right demands that duty bearers provide a set of social guarantees against deprivations of security to right holders in the form of, for example, institutions, social practices, and state powers. In the absence of such provisions the right to security would not be adequately guaranteed, and would not ensure that right holders were able to ‘actually enjoy’ the substances of their rights (Shue 1996, p.13).

In the following section, I discuss the second of the basic rights discussed by Shue, the basic right to subsistence.

1.5b – The Basic Right to Subsistence

In this section I set out how the second of the rights identified by Shue, the right to subsistence, qualifies as a basic right. To do so I first explain Shue’s argument for how subsistence meets the necessity criterion, and thus also fulfils the justified demands criterion. I then explain how the right fulfils the actual enjoyment and social guarantees conditions, and identify some of the kinds of institutions and practices that the right demands.

Firstly, Shue argues that subsistence, by which he means ‘minimal economic security’, is ‘more controversial’, or less widely accepted as the substance of a right, than physical security (1996, p.23). However, he also argues that subsistence rights may be thought ‘more basic’ (Shue 1996, p.25) than rights to security because ‘[p]eople who lack protection against violations of their physical security can, if they are free, fight back against their attackers or flee, but people who lack essentials, such as food, because of forces beyond their control can do nothing and are on their own utterly helpless’ (Shue 1996, p.25). Therefore, like the basic right to security, the basic right to subsistence is necessary for enjoyment of all other rights because, Shue argues, ‘[d]eficiencies in the means of subsistence can be just as fatal, incapacitating, or painful as violations of physical security’ (1996, p.24). As such, deprivations of subsistence goods can impede the enjoyment of rights as effectively as deprivations of physical security.

By guaranteeing access to fundamental economic goods, the basic right to subsistence contributes to the ability to enjoy all other rights by removing, or ameliorating, those impairments which render such enjoyment impossible. To illustrate, malnutrition and disease can harm and restrict important freedoms just as easily as violent action by weakening right holders to the extent that they are unable to acquire such goods for themselves (Shue 1996, p.24; Pelletier et al. 1995; Brown & Pollitt 1996; Bergstrom & Lindholm 1998; Rajeswari et al. 1999; Butler et al. 2001; Wilkinson & Marmot 2003). Therefore, the right to subsistence is basic according to Shue because, like the other basic rights, lacking such a right ‘would hinder the enjoyment of all other rights' (1996, p.25). As such, denial of either right can lead to deprivation severe enough to render enjoyment of all other rights impossible. For this reason, there are extremely good reasons for endorsing the basic right to subsistence, because failure to do so makes enjoyment of any other rights, or any decent life, impossible. As such, the basic right to subsistence also meets the justified demands aspect of Shue's definition of moral rights.

The second aspect of Shue's definition of moral rights, the actual enjoyment criterion, means that the right to subsistence entitles right holders to enjoy at least the subsistence goods necessary for 'minimal economic security' (1996, p.23). Shue argues that such goods are those things which are 'the essentials of life' (1996, p.25), and include things like 'unpolluted air, unpolluted water, adequate food, adequate clothing, adequate shelter, and minimal preventative public health care' (1996, p.23). As with the basic right to security, the second part of Shue's definition of moral rights means that the right to subsistence demands that these goods are actually accessible by all persons.

Thirdly, the social guarantees aspect of Shue's definition of moral rights means that the right to subsistence entails the provision of services and institutions which provide subsistence goods to those unable to provide them for themselves. For example, fulfilment of the right to subsistence may entail the provision of systems which guarantee housing, adequate nutrition, and a clean environment for all persons. Shue argues that while the basic right to subsistence cannot guarantee protection from all sources of serious deprivation, it can be expected to ensure that society as a whole is structured in such a way that provides ‘effective management, when necessary, of the supplies of the essentials of life’ (1996, p.25).[1]

Finally, as noted above, starvation and chronic disease can impose barriers to the enjoyment of other rights just as effective, and potentially as fatal, as deliberate violence. As such, like the basic right to security, the demand for a basic right to subsistence is supported by extremely good reasons which justify the demand. Further, in order to ensure that right holders are able to actually enjoy the substances of their rights, the right entails the existence of duties to provide social guarantees which ensure that right holders are able to actually access and make use of the substance ‘subsistence’ – which includes a wide range of goods including ‘adequate nutrition’ and ‘adequate shelter’ (Shue 1996, p.23). As such, the basic right to subsistence meets each of the three criteria to qualify as a moral right, and also fulfils the necessity condition and thereby qualifies as a basic right.

In the following section I discuss the last of Shue’s three basic rights, the basic right to liberty.

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[1] Achieving this goal may in some cases require the social provision of goods to vulnerable persons who are helpless in the face of overwhelming deprivations. However, in other cases, all that may be required is that duty bearers avoid creating barriers which make self-sufficiency impossible. That is, in some circumstances, the duties correlating to the basic right to subsistence may require only that duty bearers not prevent right holders from exercising their ability to provide for themselves (Shue 1996, p.39). I discuss the diversity of the requirements of the basic rights in more detail later in this chapter, when I outline Shue’s reasons for rejecting the distinction between positive and negative rights.

1.5c – The Basic Right to Liberty

In this section I explain how the third of the basic rights described by Shue qualifies as a basic right and how it fulfils each aspect of Shue's definition of moral rights. As in the preceding sections I first explain how liberty rights can be necessary for the enjoyment of all other rights, and thus fulfil the necessity and justified demands criteria. Secondly, I set out what the right refers to, with reference to the actual enjoyment criterion, and the kinds of actions necessary to fulfil it under the social guarantees criterion.

First, according to Shue, certain kinds of liberty right are essential for the enjoyment of all other rights because they place restraints upon the behaviour of powerful forces and enable right holders to evade abuses of power, abilities which are required for the enjoyment of other rights.[1] In the absence of liberty rights which guarantee such powers, restrictions on personal freedoms can make it impossible to enjoy other rights. For example, Shue identifies two basic liberty rights (though he acknowledges the possibility for others); firstly, the right to political participation is part of the basic right to liberty according to Shue because it provides right holders with the ability to

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[1] Liberty rights are, to many in liberal democracies, even less controversial than rights to security. They are Rawls' main concern in *A Theory of Justice* (1999a) and are frequently cited in political discourse as grounds for rejecting certain social demands. For example, many arguments offered by members of the American Republican Party in response the Obama administration's Patient Protection and Affordable Care Act (PPACA) focused heavily on the importance of preserving individual freedoms (Ron Paul Presidential Campaign Committee 2011; Rick Santorum for President 2011; Romney For President, Inc. 2012). However, Shue notes that certain kinds of liberty, such as political participation, are sometimes viewed as unnecessary, or secondary to rights to subsistence or security (Shue 1996, pp.65–66; Rodin 2012, p.39). In response to the latter claim Shue notes that some liberty rights are actually required for enjoyment of the basic rights to security and subsistence as rights. Therefore, denial of these important liberty rights results in the denial of the rights which their critics may wish to defend.

influence social policy, and protects them from misuses of governmental power which could restrict their ability to enjoy the substances of other rights (Shue 1996, p.75). Secondly, the right to freedom of movement is basic because it provides right holders with the ability to flee from the imposition of violence, and with the freedom to pursue their own goals on their own terms (Shue 1996, p.81).

Each of these liberties is important for similar reasons, they both guarantee right holders the ability to make their own decisions (or at least contribute to the making of decisions through political engagement) and they both ensure that right holders are able to escape from, or avoid, repressive, irresistible abuses of power. To illustrate, both incarcerated people and the citizens of ‘benevolent dictatorships’ are vulnerable to the violence of those agencies who control their democratic or literal freedom. In both contexts right holders ‘are at the mercy of their captors. They cannot flee and they cannot fight, and they certainly cannot make demands’ (Shue 1996, p.81).[1] As a result, while it may be possible for right holders to enjoy the substances of rights, ‘they cannot enjoy them as rights, only as privileges, discretions, indulgences. Deprivation can occur as readily as provision, and this is not what enjoying a right means’ (Shue 1996, p.81). Therefore, these important liberty rights qualify as basic rights according to Shue because they guarantee freedoms necessary for the enjoyment of other rights. As such, since liberty rights of certain types fulfil the necessity criterion, they are also supported by very

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[1] Shue notes that there are cases where restrictions of freedom of movement can be legitimate, such as in the case of the incarceration of violent criminals (Shue 1996, p.79).

good reasons, which can be taken as the rational basis of demands on others, thereby also fulfilling the justified demands criterion.

Second, the actual enjoyment criterion of moral rights requires that rights ensure that right holders enjoy access to, and use of, the substances of their rights. In the case of the basic right to liberty, this means that the right entitles right holders to freedom of movement, and to political participation, as well as the goods essential for the actual enjoyment of these rights. For example, the right may entail the provision of protection from the violence of other agents and from economic deprivation in order to ensure the actual enjoyment of the basic right to liberty. While a duty to avoid arbitrarily detaining right holders is necessary for the enjoyment of basic liberty rights, it is utopian in the extreme to believe that this is all that is required for the enjoyment of the basic right to liberty, or the other basic rights.

Third, the existence of ‘those who do not choose not to violate’ liberty rights (Shue 1996, p.39) means that, like the basic right to security, active protections must be emplaced which guarantee the basic right to liberty. Similarly, poverty and disease can impose restrictions on freedom of movement which are as restrictive as imprisonment or the use of violence. Therefore, fulfilment of the social guarantees aspect of Shue’s definition of moral rights requires the construction of systems which enable right holders to move freely, and which provide protection from the hazards which could restrict this freedom. The right also requires the provision of systems which facilitate participation in democratic procedures, since democratic empowerment is required to prevent, or at least limit, abuses of power by governments which can deprive citizens of their other rights.

The right to liberty qualifies as a basic right because in its absence, right holders are not guaranteed the freedom to flee from, or retaliate against, those who would deprive them of their rights. Further, liberty is essential in order for right holders to be able to pursue their own objectives and provide subsistence goods for themselves. As such, enjoyment of any other rights is contingent upon a basic right to liberty, because it guarantees the freedoms necessary to enjoy those other rights. As such, the right to liberty fulfils the necessity criterion and thus qualifies as a basic right.

In the following section I provide an overview of Shue's basic rights before moving on to argue for the importance of an additional basic right to health care.

1.5d – Summarising Shue's Three Basic Rights

In this section I summarise how each of the rights mentioned by Shue qualifies as a basic right and fulfils each part of his definition of moral rights.

In the previous sections I have explained how each of the three basic rights discussed by Shue qualify as basic rights by fulfilling what I have termed the necessity criterion – the requirement that a right be necessary for the enjoyment of all other rights. Each of the rights discussed in the preceding sections is also described by Shue as fulfilling each aspect of his definition of moral rights. As such, each right is supported by principles which are sufficient to justify the authority of right holders to 'make demands of others' (Shue 1996, p.13). That is, the principles which mean that the basic rights fulfil the justified demands criterion are derived from the necessity of the basic right. Since each basic right is necessary for the enjoyment of any decent life, to deny the basic rights would be to deny an entitlement to live any decent life, or to enjoy any rights. As such, according to Shue, the denial of the basic rights is something which 'no self-respecting person can reasonably be expected to accept' (1996, p.19).[1]

The basic rights suggested by Shue also fulfil the actual enjoyment criterion of his definition of moral rights, and collectively seek to ensure that right holders are actually able to enjoy states of being physically and economically secure, and at liberty. To ensure that such states are protected by reasonable guarantees, the rights also fulfil the social guarantees criterion and each demand the provision of systems which deliver, protect, or otherwise ensure the enjoyment of the states of being mentioned above.

Collectively, the three basic rights described by Shue are intended to ensure that right holders enjoy social guarantees of the actual enjoyment of the goods necessary to achieve a decent life, reasonably free from the threat of irresistible deprivations, as discussed above. The rights themselves are justified with reference to their importance to any life, and each is claimed by

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[1] This implies that at the very least there is a contractualist justification for endorsing the basic rights (Scanlon 2000, p.224).

Shue to be essential for the enjoyment of all other rights. However, although the rights Shue describes do provide a valuable set of guaranteed entitlements to right holders which will serve to protect them from a wide range of significant threats, the model does not explicitly assert the importance and complexity of health care. As I argue in the following section, if any other rights are to be enjoyed, it is necessary to acknowledge a distinct basic right to health care which provides more comprehensive guarantees than those made clear by the original basic rights model.

1.6 – The Basic Right to Health Care

So far in this chapter I have identified three criteria which must be met for candidate moral rights to qualify as actual moral rights, and a fourth 'necessity' criterion which distinguishes basic from non-basic rights. I also noted Shue's argument that basic rights are necessary for any decent life, and that as a result basic rights represent the absolute minimum morally acceptable set of entitlements owed to all right holders. In this section I argue that deprivations of health can restrict the ability of right holders to enjoy their other rights as effectively as deprivations of security, subsistence, or liberty, and that as a result, a basic right to health care[1] is necessary for the enjoyment of all other rights. To make this argument I first explain how the right to health care fulfils the necessity criterion, and how it fulfils each

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[1] As I discuss in section 1.7, while the promotion and protection of the state of health is the goal of a health related right, referring to a right to health is inaccurate. As such, I argue here for the importance of a right to health care.

aspect of Shue’s definition of moral rights.[1] I then briefly set out some of the requirements of the right, before responding to a key objection to this right in the following section.[2]

First of all, deprivations of health can restrict liberty as effectively as imprisonment, harm like assault or murder, and starve as efficiently as famine (Shue 1996, pp.20–22; Viravaidya et al. 1996; UNAIDS 2003).[3] Being deprived of one’s health, through injury, accident, or sickness, not only causes direct harm to the individual, but also restricts her ability to enjoy any other rights. For example, for those who have HIV, lacking access to antiretroviral therapy can eliminate the ability to satisfy their subsistence needs by preventing them from working (as indeed, can many other diseases) (UNAIDS 2003, pp.7, 9, 26).[4] Similarly, injury and disease can prevent participation in other social endeavours such as education or democratic

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[1] It might be objected that Shue’s definition of the basic right to subsistence already includes an entitlement to health care services as he acknowledges the importance of ‘minimal preventative public health care’ (1996, p.23) as one of the constituent elements of that basic right. However, as I discuss in more detail in chapter five, while Shue alludes to the importance of health care he does not examine it in depth and does not explicitly refer to the full range of health care services necessary to protect right holders from deprivations of health which could render the enjoyment of other rights impossible. In addition, his emphasis on purely preventative care neglects the impacts of deprivations of health and is arguably incompatible with the demands of his triumvirate of duties, particularly the duty to aid (Shue 1996, p.60), and with the broader goal of the basic rights model of guaranteeing a minimally decent life.

[2] I discuss the demands of the basic right to health care in greater detail in the following chapters.

[3] The people most affected by these deprivations, those who are victims most frequently and who suffer the worst effects, are typically amongst the world’s poorest and most vulnerable people (Viravaidya et al. 1996; Farmer 1999, p.11; Banta 2002; Herman et al. 2011). Indeed, recent commentary on poverty has suggested that rather than viewing it as an independent factor in deprivations of health, the impact that economic and social deprivations can have on health and disease may warrant treating poverty itself as more than ‘just a risk factor’ in cases of preventable death and disease (Buchman 2012, p.709).

[4] At the macroeconomic level, widespread deprivations of health can limit economic growth by hindering individual productivity (Price-Smith 2002, p.99; Sachs & Malaney 2002, p.681).

participation (Held 1995, pp.192, 194–195; Brown & Pollitt 1996; Nussbaum 2003, pp.41–42; Brock 2009, p.66) by making it impossible for right holders to attend the facilities where such practices take place. In addition, deprivations of health can make it impossible to flee violence due to restrictions on mobility that can be imposed by severe disease and injury.

In addition, denials of rights to health care are also denials of the moral status of right holders because the right is necessary for the ability and authority to make demands of others about any other rights. To deny this authority by denying the basic right to health care (or any basic right) is to deny that right holders have the moral status necessary to make any demands of others, and thus to deny their entitlements to the substances of any rights. Therefore, adequately respecting the moral status of all persons, and guaranteeing the actual enjoyment of any other rights, is dependent upon guaranteeing the enjoyment of at least a threshold level of health, through fulfilment of the right to health care.

Like security services, health care contributes to the provision of a safe context in which all rights may be enjoyed by providing protection from harmful threats to wellbeing. The only difference between these goods is that security protects against the actions of agents, while health care provides guarantees against disease and accidental injury. In addition, the basic right to health care entails the provision of aid in cases where deprivations of health have been caused by malicious action, as I discuss in chapter four. Failure to guarantee access to either security or health care undermines this safe context and exposes right holders to violent or health-related hazards which can render enjoyment of other rights impossible. It is irrelevant to the right holder, and to the basic rights model, whether their temporary incapacity is the result of violent action, accidental injury or serious disease for example, and all three can impose major restrictions on the ability to enjoy other rights. Therefore, a right to at least basic health care services fulfils the necessity condition because it provides the safe context in which other rights may be enjoyed. It thus qualifies as a basic right. Consequently, the basic right to health care also fulfils the justified demands aspect of Shue's definition of moral rights, since the necessity of a right to health care for all other rights provides good reasons which can justify right holders making demands that they be guaranteed access to at least basic health care services.

Fulfilment of the second, actual enjoyment, criterion of moral rights by the basic right to health care requires that right holders are able to actually access, use, and benefit from the services necessary to provide them with a reasonable guarantee of at least a minimally acceptable standard of health. As I set out in detail what goods and services are guaranteed by the basic rights model in the following chapters, I shall not pre-empt that discussion here. In the context of the basic right to health care, the social guarantees criterion entails the existence of duties to contribute to the promotion and protection of health, as I argue in the following chapters. The kinds of duties required by the basic right to health care include obligations to contribute to the provision of health care services, and to the efficacy of public health programmes, such as vaccination (Anderson & May 1985; Colgrove 2006), as well as duties to avoid behaviours which are likely to cause deprivations of health. For example, national governments might be obliged to avoid participating in economic practices which make it impossible for poor nations to respond to the medical needs of their citizens (Buchan 2002; Pogge 2008b; Brock 2009, pp.198–200).[1]

In this section I have argued that because deprivations of health can limit the ability of right holders to enjoy their other rights in the same way as deprivations of physical safety, subsistence, or liberty, a basic right to health care is necessary for the enjoyment of all other rights. As such, it fulfils the necessity criterion and qualifies as a basic right. I also noted that, like the basic rights identified by Shue, the necessity of a health related right means that there are extremely good reasons for endorsing it. As such, it fulfils the justified demands criterion of moral rights. Further, fulfilment of the actual enjoyment and social guarantees criteria means that the right entitles right holders to guarantees of access to at least basic health care services. This entails the existence of a complex set of duties, the exact nature of which is explored in the following chapters.

So far I have argued that a basic right to health care is necessary for the enjoyment of all other rights. I have noted that the goal of this basic right to health care is the promotion or protection of health, since it is the status of

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[1] I discuss these requirements in more detail in the following chapters when I present a full outline of the duties required by the basic right to health care.

being healthy which enables right holders to enjoy their other rights, and that health care is merely the means by which health is preserved. As such, while I have referred to a basic right to health care in the previous sections, it might be objected that the health related basic right is more accurately a right to health, rather than health care.[1] I discuss this claim in more detail in the following section.

1.7 – Health or Health Care? Establishing Accurate Terminology

In this section I argue that the appropriate term for the health related right with which I am concerned is a right to health care, rather than health. To make this argument I make three claims; first, that it is not possible to guarantee all persons perfect health and so a right to health is impossible. Second, that providing a guarantee of perfect health or total immunity against deprivations of health is not required by the basic rights model. Third, that even a right to health would not provide health but merely the means to it so the appropriate terminology would refer to a right to health care. To make these arguments I first argue that while it may appear that this nominative convention should also apply to the rights identified by Shue, the terminology he uses for these rights is correct.

Each of the basic rights described by Shue offers a limited, context dependent guarantee of access to goods which promote and protect the ability of right holders to enjoy the substance of the right in question. For example, the right

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[1] Jonathan Wolff's recent, and excellent, book *The Human Right to Health* uses the terminology of a right to health for example (Wolff 2012).

to security provides guarantees of non-intervention and protection from violations of personal, physical safety and in doing so enables right holders to enjoy the substance of the basic right to security, which is of course security. Similarly, the basic rights to liberty and to subsistence provide guarantees of access to sets of goods, including adequate nutrition and the electoral franchise. Access to these goods enables enjoyment of the substance of the basic right to which they correspond in a similar fashion to the way in which access to police protection enables enjoyment of the substance of security.

In each of these cases what is guaranteed by the right in question is, in a sense, not the actual substance of the right, but rather a set of resources, entitlements, and guaranteed behaviours which collectively serve to enable right holders to enjoy that which the right entitles them. However, while each of the basic rights guarantees their substance only indirectly, it seems reasonable to refer to them in terms of the substances which they guarantee. For example, a right which guarantees access to a police service, laws, and the restraint of malicious behaviour is referred to as a right to security, since security is the ultimate objective of that right.

Following Shue’s nominative convention, it would appear that the right with which I am concerned should appropriately be termed a basic right to health, rather than a right to health care. However, while I do not wish to challenge Shue’s terminology for the rights that he has described, I do wish to resist this convention and talk instead in terms of a right to health *care*. While it is true that a right to health would appear to fit more comfortably with the conventions of the discourse established by Shue, to talk about a right to health is unappealing for three reasons. The first two of these reasons might justifiably also be levelled against the terminology used by Shue, while the third point refers to a more fundamental difference between the rights which Shue describes, and the right to health care. Since my focus is not on challenging the terminology adopted by Shue I shall only mention the first two points briefly, before considering the third issue in more depth.

Firstly, by Shue's own acknowledgement, and by the theoretical constraints of his model (1996, pp.29–33), providing absolute guarantees of health, security, subsistence, or liberty is both impossible and unnecessary for the fulfilment of the rights in question.[1] The basic rights are instead intended only to provide reasonable minimum standards of defence against standard threats to wellbeing (Shue 1996, p.33), and guarantees of what is necessary for enjoyment of other rights and the enjoyment of a minimally decent life. As such, to define the right with which I am concerned as a right to health is to imply a set of guarantees which are impossible to fulfil, and which go beyond what is demanded by the basic rights model. Secondly, as noted above, the entitlements guaranteed by a right do not guarantee the substance of the right itself, but rather the goods and services necessary for enjoyment of it. For example, a right to health would not guarantee health, but rather

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[1] It is worth noting that Onora O'Neill has argued that a right to health is impossible, because providing perfect health to all persons is beyond our capabilities (O'Neill 2002, p.10).

access to things like vaccinations, sanitation, and medical treatment, which collectively serve to preserve, protect, and promote health. As such, to talk in terms of a right to health is to misrepresent what it is that the right guarantees. This inaccuracy is compounded by the fact that health, unlike the substances of the basic rights described by Shue, and despite the impacts of social factors, remains a fundamentally internal state of individual agents.

My main argument for suggesting a right to health care rather than health is based on the above claims, and focuses on the differences between the substances of the original basic rights as described by Shue, and on the basic right to health care proposed in this thesis. I noted at the start of this section that what each of the basic rights guarantees is, in a sense, not the substance of the right in question, but rather a set of goods, services, and behaviours which serve to enable or facilitate enjoyment of that substance. For this reason, I suggested that the term ‘right to health care’ is a more accurate description of what is guaranteed by the right in question than the term ‘right to health’. It might also be suggested that, following this line of argument, each of Shue’s basic rights should also be phrased as rights to ‘security-care’, ‘subsistence-care’, or ‘liberty-care’. These terms are perhaps less linguistically graceful, but it might be argued these are the correct terms to use, in line with the arguments presented in this section. However, while the basic rights to security, subsistence, and liberty actually guarantee sets of goods which enable enjoyment of the substances for which each right is named, it is also true, in a sense, that the original basic rights do provide their substance to right holders, unlike any health related basic right.

Each of the basic rights originally described by Shue guarantees a set of goods which enable enjoyment of the substance of the right; this is also true of the right to health care. In the case of the rights to security, subsistence, and liberty however, the term for the substance of each right, of the state of being that it is trying to facilitate, is also the collective term for the goods, services, and behaviours used to guarantee that substance. This is most clear in the context of the basic right to security. Security is a state of being in which one is secure, but it is also a word which in common usage refers to the collective goods used to guarantee that state of being. Security checks at airports are used to guarantee the status of being secure, for instance. Similarly, liberty is the state of being in which one is at liberty to do what one likes, but it can also (though less straightforwardly) refer to the collective freedoms to which one is entitled in virtue of one's liberty rights. Finally, subsistence refers to a particular minimal standard of economic power; talk of subsistence farming is common for example. Yet it can also refer to the products of subsistence activities, or to the goods provided that enable enjoyment of that minimum standard, such as subsistence crops.

The identifying terms used to refer to the substances of Shue's original basic rights also refer to the goods that the rights guarantee, and which enable enjoyment of the substance of the right. As such, Shue's basic rights avoid the inaccuracy problem mentioned above. However, the same is not true for health, since in plain language the word 'health' does not refer to both the state of being healthy and the goods needed to ensure that state. At most, the goods in question *provide* health, but generally speaking it is more intuitive to talk about treatment, medication, care, or support. As such, while the terminology of the original basic rights can be seen to refer to their substances as both verb and noun,[1] no such confluence of terminology or meaning exists for health and health care. Therefore, while the objective of any health right is to ensure good health, the right itself is actually a right to health *care*.

In this section I have argued that while the objective of a right to health care is to contribute to the promotion and maintenance of the state of being healthy, it should not be considered a right to health, but rather a right to health *care*. This distinction is important, and is based on three main factors; firstly, it is impossible to ensure that all persons are healthy at all times.[2] Second, given the strict limits of Shue's model and his emphasis on providing only basic goods, guaranteeing perfect health is not required by the basic rights model. Third, I argued that the term 'right to health' is inaccurate, given that what is guaranteed by the right is not health but rather a set of goods and services which aim to promote it. Therefore, I argued, the term 'right to health care' presents a more accurate picture of what is provided by the right in question. However, I also noted that this objection to the term 'right to health' might also be made against the terms used by Shue for the

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[1] For example, the basic right to security is intended to ensure security as a state of being (security as verb), and as a means to guaranteeing it through a specific set of goods (security as noun).

[2] This is true to a far greater extent for health than it is for the other basic rights, even acknowledging the improbability of being able to guarantee perfect security etc. at all times.

original basic rights, since they also guarantee a set of goods and services intended to ensure enjoyment of the substances of the rights in question.

This claim led me to the main reason for adoption of the term ‘right to health care’, and for my acknowledgement of the appropriateness of Shue’s terms for his three original rights. The main reason for referring to a right to health care rather than health, but for retaining Shue’s original terminology is that for each of Shue’s original basic rights, the word used for the substance of each right, security, subsistence, or liberty, may also refer to the goods used to promote or protect that substance. This is not true for the word health, since the collective term for the goods and services that promote and maintain health is health care. Therefore, the appropriate term for the basic right, the object of which is the promotion of health, is a right to health care.[1]

So far in this chapter I have identified four identifying features of basic rights, explained how the right to health care fulfils these criteria, and why it is appropriate to refer to a right to health care rather than health. In the sections that follow I explain the nature of the duties corresponding to the basic rights. I begin this discussion in the following section by explaining

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[1] Other theorists have argued that that health is the appropriate term to use when discussing health related rights, and that health is the actual substance of such rights (Venkatapuram 2011; Wolff 2012). While I do not think that this is accurate, replacing the phrase ‘right to health care’ with ‘right to health’ would not change the underlying arguments of this thesis, nor any of the substantive philosophical argument I present. Rather, it would instead merely offer a different terminology with which to discuss the issue of global health justice. However, since the objective, to argue for a health related basic right, of this thesis would remain unchanged regardless of which phrase is used, I shall not object if the other term is preferred, though in this thesis I use the term right to health care, and shall not discuss the issue further.

how the requirements of the basic rights mean that they resist clarification as either positive or negative rights.

1.8 – Rejecting the Positive/Negative Rights Distinction

In the previous sections I set out the four identifying features of basic rights, and explained how the rights identified by Shue, and the right to health care with which I am concerned in this thesis, fulfil these criteria. I also offered a brief explanation of some of the requirements of each of these basic rights. In the following sections I set out Shue's triumvirate model of duties, and briefly explain how it corresponds to the basic rights. First however, in this section I set out a central feature of Shue's argument – his rejection of the distinction between positive and negative rights. Shue's rejection of this distinction is intended to apply to all moral rights, and as such is not a distinguishing feature of basic rights. Instead, Shue's rejection of this paradigm is intended to correct what he argues is a mistaken assumption in rights theory generally.

Shue rejects the distinction between positive and negative rights by arguing that adequate fulfilment of any right will require *both* action *and* restraint (1996, p.37). In this section I set out Shue's arguments for rejecting the positive/negative distinction and explain its importance for the basic rights model. To do so I first explain Shue's assessment of the positive/negative rights assumption, before setting out the two reasons he gives for rejecting it and for endorsing the heterogeneity of all moral rights.

Shue notes (1996, pp.36–37) that there is a frequent distinction drawn between subsistence and security rights on the grounds that the former are ‘positive’ and require active engagement, while the latter are ‘negative’ and require only passivity in the face of opportunities to harm (Cranston 1963, pp.36–37, 54; Frankel 1978, pp.36–49; Nagel 1991, pp.114–115). Shue suggests that the right to subsistence is often thought to be a positive right because ‘it would require other people, in the last resort, to supply food or clean air to those unable to find, produce, or buy their own’ (1996, p.37). In contrast ‘a right to security would be negative because it would require other people merely to refrain from murdering or otherwise assaulting those with the right’ (1996, p.37). In addition, Shue argues that ‘positive’ rights are taken to be of secondary importance to ‘negative’ rights because positive rights may require agents to do more than negative rights and potentially more than what is actually possible for those agents (1996, p.37). As such, Shue states it is assumed that fulfilment of ‘negative’ rights should take priority over fulfilment of ‘positive’ rights, which should be addressed with any ‘remaining resources’ (1996, p.37). Shue argues that this perspective is mistaken because it is based on inaccurate assumptions about the nature of rights.

Shue suggests two key reasons for rejecting the above binary distinction between positive and negative rights which I set out below; first, adequate fulfilment of *any* right, i.e. fulfilment which enables the ‘actual enjoyment of a substance’ as discussed above, will entail both positive and negative action on the part of duty bearers. Second, the status of the basic rights as prerequisites of all other rights means that even if rights were themselves entirely positive or negative, their dependence upon the fulfilment of other basic rights means that they will require both positive and negative actions to be fulfilled.

First then, implicit to Shue’s definition of moral rights discussed in section 1.2 is the claim that all moral rights require the performance of at least some ‘positive’ actions in order that they are fulfilled. This is implied by the second and third criteria of the definition, which demand that the ‘actual enjoyment of a substance’ be ensured by the provision of social guarantees (Shue 1996, p.13). This demand calls for the active fulfilment of the duty by duty bearers, even for rights which might traditionally be seen as negative. For example, as discussed in section 1.5a fulfilling security rights requires more than mere restraint, since it will require the provision of systems which protect right holders from ‘those who do not choose not to violate [their rights]’ (1996, p.39). That is, since there are people who do not fulfil their negative duties not to harm, ensuring that right holders are actually able to enjoy their right to physical security requires active engagement with the duty, and the provision of systems which protect from the actions of those who do not fulfil their duties not to cause harm.

This is not to suggest however, merely that all rights are positive rights, since in some cases restraint is all that will be required. For example, while sometimes it may be necessary to provide subsistence goods to the vulnerable in times of need, a positive requirement of the duty, Shue argues that in some contexts meeting the demands of the right to subsistence, or other rights, will only require avoiding depriving right holders of their ability to provide for themselves (1996, p.40). Shue also claims that it is not necessarily true that fulfilment of supposedly negative duties will be cheaper or easier than fulfilment of positive ones. For example, Shue argues that it may be more difficult and demanding to guarantee the 'negative' right to security in cases requiring the maintenance of an expensive police force, than it is to fulfil the demands of the right to subsistence when all that is required is the absence of harmful interventions on right holders (1996, pp.38–40).

Second, the interrelated nature of the basic rights, and their necessity for all rights, also contributes to Shue's critique of the 'positive/negative' view of rights. Since the basic rights are each dependent upon each of the others, even if it were true that each right conformed to their classic stereotype (subsistence rights are positive, security and liberty rights are negative), their reliance on the fulfilment of each of the other basic rights, would mean that all rights depended upon both positive *and* negative duties. For example, a right to freedom of movement will require both the absence of restraint, and the fulfilment of the right to security, in the form of guarantees that restraint will not be imposed by malicious parties. Therefore, attempting to set precise boundaries between positive and negative rights, even for those rights which appear focused on the absence of restrictions, such as the basic right to liberty, is impossible because every basic right will require both active and passive behaviours to ensure that right holders are able to 'actually enjoy' the substances of their rights (Shue 1996, p.13). In this way, Shue's rejection of the positive/negative distinction is partially a consequence of the necessity condition of basic rights, since the interdependence of the basic rights means that no right is entirely positive or negative.

Shue's rejection of the positive/negative distinction is an important theoretical aspect of the basic rights model because, as I discuss in more detail in the following section, it entails a demand for a more comprehensive set of duties than those required by a model which adhered to the positive/negative view of rights. As a result, the basic rights model provides more comprehensive and reliable protections to right holders because of Shue's insistence on the importance of the 'actual enjoyment' of the substances of rights (1996, p.13), and his claim that the basic rights are the necessary conditions for the enjoyment of all rights. In the following section I explain Shue's model of duties.

1.9 – Shue's Triumvirate of Duties

In order to respond to the comprehensive demands of the interconnected basic rights which he proposes, Shue suggests a set of correlating duties which are themselves closely related (1996, p.60). Each of the duties described by Shue is intended to cover one aspect of a broad spectrum of requirements necessary for enabling the actual enjoyment of the substances of each of the basic rights. In this section I discuss each of the duties in turn and explain how they correspond to the requirements of the basic rights. In doing so, I first set out the three duties defined by Shue. Second, I note three features of these duties. Third, I briefly discuss the structure of Shue's triumvirate, and explain Shue's statement of the relative importance of the duties. I do not focus on any particular basic right but instead illustrate the way in which the model proposed by Shue accounts for the general requirements of the rights he describes.

Shue presents three categories of duty, with both the second and third duties containing sub-clauses which describe more specific requirements of the duties in question;

> 'I. To avoid depriving
>
> II. To protect from deprivation
>
> 1. By enforcing duty (I) and
> 2. By designing institutions that avoid the creation of strong incentives to violate duty (I)
>
> III. To aid the deprived
>
> 1. Who are one's special responsibility,
> 2. Who are the victims of social failures in the performance of duties (I), (II-1) and
> 3. Who are the victims of natural disasters'
>
> (1996, p.60)

Each of these duties and how they apply to the basic right to health care is discussed in depth in the following chapters. However, it is first worth noting three features of Shue’s triumvirate as it relates to the basic rights that he describes. First, the three duties are closely related, with the first and second duties being ‘systematically interdependent’ (Shue 1996, p.60). Indeed, as is apparent from Shue’s first condition of the duty to protect from deprivation, the duty is intended to ensure compliance with the duty to avoid depriving. Second, the duties to avoid depriving and to protect from deprivation are pre-emptive duties, while the duty to aid the deprived is reactive (since it is a duty to respond to deprivations). Third, and perhaps most importantly, fulfilment of each of the three duties is essential in order for any right to be effectively enjoyed. ‘It is impossible’ Shue argues ‘for any basic right – however ‘negative’ it has come to seem – to be fully guaranteed unless all three types of duties are fulfilled’ (1996, p.53).

Importantly, while the duties engage in different ways, and in different orders (since the duty to aid can only function after deprivations have occurred, while the other duties occur prior to the onset of deprivation), the ordering or structure of the duties presented by Shue is not intended to demonstrate any kind of necessary priority. Shue does however note that in many cases fulfilment of, or responding to, the duty to aid will often have the

> ‘highest priority, because they are often owed to persons who are suffering the consequences of failures to fulfil both duties to avoid and duties to protect...These people will have been totally deprived of their rights to subsistence if they are not then aided either’
>
> (1996, p.62)

This said, Shue also points out that while fulfilment of the duty to aid is often important, it is also the case that better fulfilment of the pre-emptive duties will often result in fewer instances in which aid is needed (Shue 1996, pp.62–63). In parallel, situations where the pre-emptive duties have not been met sufficiently may generate ‘virtually Sisyphean duties to aid’ (Shue 1996, p.63). Therefore, while in some circumstances it may be necessary to prioritise fulfilment of the duty to aid over the other duties, generally speaking, prioritising the pre-emptive duties will minimise both the frequency of situations in which aid is necessary, and the extent of the aid required when such cases arise (Shue 1996, p.63).[1]

Each of these duties is intended to respond to one aspect of the myriad ‘standard threats’ to wellbeing with which Shue is concerned (1996, p.13). The duty to avoid depriving is largely concerned with requiring restraint, and conscientious and impartial action from duty bearers, while the duty to protect focuses on enforcing the duty to avoid depriving and on preventing those harms which are caused by malicious action and, at least as it applies to the basic right to health care, agent-independent circumstances. Finally, the duty to aid the deprived serves to respond to deprivations which do occur and to ensure that right holders are not abandoned below the decent life threshold. In this way, the three duties might be seen to engage, at least in certain aspects, sequentially, with the duty to aid engaging last. In the following sub-sections I discuss each of the duties in turn and explain how each aspect of

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[1] See for example (Abdel-Wahab 1982, p.146; Hurley et al. 1997; Riedel et al. 2001; Sanders & Taira 2003; Kjetland et al. 2006).

Shue’s triumvirate responds to the broad requirements of the basic rights model.

1.9a – The Duty to Avoid Depriving

The duty to avoid depriving (Shue 1980, p.60) is phrased as the most passive of Shue’s three types of duty, though it includes demands for significant positive action. While the duty includes a requirement to not act maliciously, it also requires agents to act conscientiously with regard to the potential consequences for others of otherwise morally neutral behaviours. In addition, the duty requires duty bearers to avoid behaviours which will make fulfilment of the basic rights of other right holders impossible, and demands that the interests of all agents are valued impartially. I discuss the requirements of this duty in the context of the basic right to health care in the following chapter.

1.9b – The Duty to Protect From Deprivation

The duty to protect from deprivation occupies an intermediate role in the triumvirate of duty. In Shue’s original description of the duty it serves to enforce the duty to avoid depriving and to establish just institutions which avoid incentivising depriving behaviour (Shue 1996, p.60). In the context of the right to health care the second condition also requires, as I discuss in chapter three, the provision of protection against at least some agent independent threats to health. Importantly, Shue’s original formulation of the duty is focused on controlling the harmful behaviours of agents, hence its emphasis on enforcement, the creation of just institutions, and its close relationship to the duty to avoid depriving. Despite the strength of the protections offered by this duty I argue that it is not entirely sufficient for the health care context.

The duty to protect from deprivation is defined by its close relationship to the duty to avoid depriving (1996, pp.62–63). Indeed, the first sub-clause of the duty to protect from deprivation entails a duty to enforce the duty to avoid depriving. As such, it is a duty to prevent violations of rights and ensure that individuals and institutions adhere to relevant regulations and moral imperatives. Shue suggests that in a world of perfect beneficence there may be little need for the duty to protect as there would be no threats of deprivation caused by agent behaviour (1996, p.61). However, he argues that in the current global situation 'organizations and individuals who will voluntarily avoid deprivation...because they know that their potential victims are protected, cannot be expected to behave in the same way when they know their potential victims are without protection' (1996, p.61). However, Shue argues that 'heavy reliance' (1996, p.60) on the duty to protect and its more restrictive measures, such as police forces and surveillance technology, rather than reliance on 'self-restraint by individuals, corporations, and lower-level governments' (Shue 1996, p.60) would lead to potentially greater problems because 'this much power to protect would also be enormous power to deprive' (1996, p.61). Therefore, Shue argues, 'for all practical purposes it is essential to insist upon the fulfilment of both [the duty to avoid depriving and the duty to protect from deprivation], because complete reliance on either one alone is probably not feasible and, in the case of duties to protect, almost certainly not desirable' (1996, p.61).

The duty to protect is intended to account for the inevitable tendency of some agents to fail to live up to the demands of their duty to avoid depriving, and to ensure that social, economic, and political structures do not serve to incentivise the dereliction of duty. The duty to protect is therefore derived from the duty to avoid depriving, and the recognition that perfect fulfilment of that duty is unlikely without further protection. I discuss the health care requirements of the duty to protect from deprivation in more detail in chapter three.

1.9c – The Duty to Aid the Deprived

The third duty defined by Shue is the duty to aid the deprived, which is owed to agents who are one's 'special responsibility', or who have been deprived because of failures of the prior duties, or as a result of natural disasters (1996, p.60). These qualifying conditions extend to cover a wide range of persons. For example, the special responsibility condition might extend to family members, but could also reasonably be taken to mean that governments have duties to their citizens (Nickel 1993, pp.80–81). Similarly, the 'social failures' (Shue 1996, p.60) condition can be taken to have a wide remit, especially considering the extensive harms which may be caused by unjust public policy, or the negligent actions of multinational agents.[1] Finally, the

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[1] I discuss these points in more detail in chapter four.

extent of the ‘natural disasters’ (1996, p.60) condition could also be broad. For example, it may be possible to restrict the definition of natural disasters to include things like earthquakes or hurricanes, but the category might also be extended to include things like outbreaks of epidemic or pandemic disease, or occurrences of famine.[1] As such, while the categories of agent to whom the duty is owed may appear restrictive, it could be reasonably understood as broad.

The duty to aid the deprived is a reactive duty, since it focuses on providing assistance to those who have been harmed as a result of the failures of the other duties or encounters with non-agent caused deprivations of the substances of rights. Where the first two types of duty are intended to prevent right holders from being made unable to enjoy the substances of their rights, the duty to aid is intended to ensure that when deprivations occur right holders do not become permanently deprived and receive assistance to achieve at least the decent life threshold. I discuss the demands of the duty to aid the deprived in more detail in chapter four.

1.9d – Summarising Shue’s Triumvirate of Duty

Shue’s model of duties is intended to respond to the comprehensive requirements of the basic rights. Each aspect of the triumvirate of duties requires a broad range of actions which will collectively serve to guarantee

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[1] Sen has for example argued that famine is not a natural phenomena (1999, p.16), and we should also note that social factors do have an impact on the outcomes of more ‘conventional’ natural disasters (Callaghan et al. 2007; Neumayer & Plümper 2007), and recognise that these factors indicate that natural disasters also have social components.

enjoyment of the basic rights. Importantly, while each of the duties demands a spectrum of types of engagement, what is required by each duty at different times will vary according to the situation, and the agents involved in them. In some cases, all that will be required of one agent by the duty to avoid depriving will be that she refrains from acting in harmful ways towards other people. In others, the agent may have to actively perform specific actions in order to meet the demands of the duty. Similarly, the duties do not necessarily demand the same types of behaviour from different agents; those with more power, or a different relationship to a specific right holder, may be required to perform more demanding duties than those without this relationship, or with less power to act. For example, the duty to protect from deprivation might require that most individual agents merely contribute through taxation to the provision of a well trained police force and legal system, and serve as jurors when necessary. In contrast, governmental agents may be required to administer that system and the funds provided to pay for it. Correlatively, a corporate agent, such as a private company, may be required to pay taxes, but cannot be asked to serve on a jury for obvious reasons. I discuss these and other questions in more detail in the following chapters when I analyse the requirements of the different duties in the context of the basic right to health care.

So far in this chapter I have explained the conditions which a right must satisfy in order to qualify as a basic right. I then argued that like the three basic rights described by Shue, the right to health care meets these conditions and therefore qualifies as a basic right. Having done so, I then argued that while it might seem more in keeping with the naming conventions of Shue's model of basic rights to refer to a basic right to health, it is more appropriate to refer to a right to health care. In this section I have provided a general outline of Shue's model of duty, though for the sake of brevity I have refrained from explaining how each duty applies to each right. In later chapters I examine each of the three duties in greater detail, and discuss the ways in which they apply to the basic right to health care. First however, I conclude this chapter by arguing that Shue's model of basic rights and their corresponding duties is an effective model for addressing questions of global justice in general, and global health care justice in particular.

In the following section I set out three important advantages of Shue's model, and compare it to other approaches which might also be considered to provide viable models for addressing problems of global justice.

1.10 – The Advantages of the Basic Rights Model For Analysing Questions of Global Justice

So far in this chapter I have explained Shue's definition of moral rights and his explanation of what it means for a right to be basic. Having done so, I argued that health care is necessary for the enjoyment of all other rights and that a right to health care fulfils what I have described as the *necessity* criterion. As such, I have argued that adequately guaranteeing any rights entails the provision of a basic right to health care which entitles right holders to at least basic health care services.

In this and the following sections I argue that the basic rights approach to global justice benefits from significant theoretical clarity along three key vectors, which collectively endow the model with valuable simplicity, directness, and breadth. This is valuable, as I discuss below, because it allows for simpler theorising about the specific requirements and implications of the basic rights model, and provides more reliable guarantees to right holders that their rights will be protected. While I discuss the benefits of the basic rights model with reference to other approaches to global justice theory, I do not mean to claim that the basic rights model is in all ways superior to these alternatives. Indeed, many of the ideas contained within the models I discuss are compatible with, and complementary to, the argument I propose in this thesis.[1] Nor do I claim to provide a full account of each alternative model. Instead, my goal is merely to use these alternatives to highlight the key strengths of the basic rights model, and thus justify my framing my analysis of the global health justice debate in terms of the basic rights model.

My claim is that there are three consequences of the structure of the basic rights model which are advantageous in theorising about global justice. Firstly, the interrelatedness of the basic rights means that the model provides clarity of justification for the rights which it describes. Secondly, the comprehensiveness of Shue's triumvirate of duties makes the extent of the duties correlating to rights clear, accounts for differences in duties owed by

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[1] Further, there are certainly ways in which Shue's model can be criticised. However, I do not consider them in any detail here, leaving that discussion for chapter five when I discuss four categories of objection to the basic rights approach and to my argument for a basic right to health care.

different right holders, and provides better guarantees of the adequate enjoyment of the substances of rights. Thirdly, the substantive nature of the basic rights model makes the goal of the basic rights model explicit, providing clarity of objective.

In the following sub-sections I discuss these features of the basic rights model in turn and compare it to alternative approaches to global justice.

1.10a – Clarity of Justification

In this section I argue that Shue’s argument for the interdependence of the basic rights, as discussed in sections 1.3 and 1.8, provides a valuable theoretical justification for the importance of rights which are often neglected or inadequately theorised (Shue 1996, p.65). To make this argument I first restate Shue’s argument for the interdependent nature of the basic rights. Second I explain the implications of this interrelatedness, before finally explaining the value of these implications in terms of justificatory clarity.

First, according to Shue, rights are basic when they are fundamentally necessary for the enjoyment of all other rights.[1] A consequence of this is that some rights, to subsistence for example, which are assigned lower priority by those who adhere to the distinction between positive and negative rights (Cranston 1963, pp.36–37, 54; Frankel 1978, pp.36–49; Nagel 1991, pp.114–115) are claimed by Shue to have great importance as necessary conditions

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[1] I explained this necessity condition, and the interdependence of the basic rights in section 1.3.

for the enjoyment of other, less ‘controversial’, rights (1996, pp.22–23).[1] In doing so, and in articulating the interdependent relationship between basic rights, Shue provides a theoretical justification for the importance of subsistence rights which is compatible with arguments which prioritise liberty or security rights. For example, in *The Law of Peoples* Rawls acknowledges the importance of access to basic health care for democratic stability within nations (1999b, p.50), and endorses Shue’s argument for the importance of ‘all-purpose economic means’ as conditions of democratic stability (1999b, p.65).

Rawls’ second principle of justice[2] might be argued to be sufficient to guarantee the subsistence goods identified by Shue, and to thus render Shue’s argument for the importance of these goods superfluous. However, Shue’s analysis of these goods and their importance is more complete and explicit than that provided by Rawls. As such, Shue’s analysis of the interdependent nature of rights, and his claim for the importance of subsistence rights, provides the theoretical framework which supports and clarifies Rawls’ analysis of the demands of ‘democratic peace’ (1999b, p.50). Further, by proposing an instrumental argument for the importance of subsistence goods, Shue provides a theoretical basis for rejecting claims to the paramount importance of liberty. For instance, the vocal opposition to the Obama Administration’s Patient Protection and Affordable Care Act (PPACA)

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[1] Indeed, one of Shue’s main objectives in *Basic Rights* is to ‘rescue from systematic neglect’ the kinds of economic rights which he argues are ignored by ‘wealthy North Atlantic nations’ (1996, p.65).

[2] ‘that social and economic inequalities be arranged so that they are ... to the benefit of the least advantaged’ (Rawls 1999a, p.266).

(Patient Protection and Affordable Care Act 2010) was largely based on demands for the absolute prioritisation of liberty over the individual welfare of those unable to access health care services.[1] While Rawlsian theory might suggest that these claims are libertarian rather than liberal, and contrary to the maintenance of democratic peace (Rawls 1999b, pp.49–50), Shue's analysis of the importance of subsistence rights provides a clear theoretical basis for explaining why such 'libertarian' claims are untenable in more detailed terms than can be provided by Rawlsian theory.

The detailed justification Shue offers for the importance of subsistence rights provides a more thorough explanation of the importance of these rights than other models, even if those models also endorse subsistence rights. As a result, Shue's model enjoys significant theoretical clarity, which is valuable for theorising about global distributive justice. In the absence of a clear explanation of the importance of subsistence goods, even if they are implied by more general theoretical approaches, it is more likely that they will be ignored or neglected as Shue has argued has occurred in US foreign policy (1996, p.6). As such, as a model for analysing questions of global justice and for affecting policy change, the clarity of justification provided by the basic rights model is of significant value.

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[1] I have discussed the assumptions which support objections to the provision of public health care in more detail elsewhere (West-Oram 2013). In this paper I also consider the way in which these assumptions ignore, and tacitly endorse, the significant harms suffered by people as a result of the prioritisation of only certain kinds of liberty right.

In the following section I explain how the breadth of Shue's triumvirate of duties clarifies the range of obligations necessary for the fulfilment of the basic rights, and provides better guarantees to right holders than approaches which focus on the fulfilment of negative duties.

1.10b – Clarity of Obligation

In this section I explain two benefits which derive from the breadth of Shue's triumvirate of duties. First, I argue that the scope of Shue's triumvirate of duties means that it provides a clearer outline of the requirements of rights, and more comprehensive guarantees to right holders than are provided by alternative models. Second, I argue that Shue's triumvirate is broad enough in scope to accommodate the obligations owed by both individual and institutional or corporate agents. As a result the basic rights model enjoys clarity of obligations, both in terms of what the obligations correlating to rights are, and in terms of the agents who are responsible for fulfilling them.

To make this argument I first reiterate Shue's argument for rejecting the positive/negative distinction. Second, I note two issues that arise from treating positive duties as derivatives of past failures to fulfil negative duties. Third, I argue that the triumvirate of duties proposed by Shue applies to a wider range of contexts than models which focus on negative duties, and thus provides more reliable guarantees of the enjoyment of rights. Fourth, I note the different levels of ability to fulfil duties held by different types of agent, and argue that Shue's triumvirate is able to explain the duties owed by different types of agent.

As discussed in section 1.2, Shue states that rights must guarantee the actual enjoyment of their substances in order to qualify as rights to that substance. A consequence of this requirement is that rights, according to Shue, cannot be categorised as being either positive or negative since ensuring the actual enjoyment of the substance of any right will entail the fulfilment of both positive and negative duties, as discussed in section 1.8. To respond to this requirement, Shue proposes a triumvirate model of duties, as described in section 1.9.

By rejecting the distinction between positive and negative rights and duties, Shue rejects claims that all that is necessary for the fulfilment of rights is the absence of harmful behaviours. In addition, he asserts the importance of positive duties as an essential component of the adequate fulfilment of rights. In doing so, he provides an alternative to models which focus exclusively on negative duties, while acknowledging the importance of such duties. However, other approaches, most notably that suggested by Thomas Pogge (2008c) (with others), accept the priority of negative duties, but propose extensive positive duties which are derived from past failures to fulfil those negative duties.[1] Pogge's ‘liability-focused’ model makes significant claims about the consequences of failures to fulfil negative duties, and argues for the

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[1] Sridhar Venkatapuram’s recent work on health justice also emphasises the importance of duties based on liability for harm (2011, p.4).

existence of demanding positive obligations to right holders which are derived from past failures to fulfil negative duties.[1]

In arguing for a model of positive duties which are derived from negative duties, Pogge presents an argument which he claims should be accepted even by those who ordinarily deny the existence of positive duties (2008c, pp.26–30). Pogge's argument is compelling, and draws on many examples of the harms inflicted on vulnerable people by the actions of the powerful (2008c, pp.224–225). His approach also provides a valuable justification of positive duties in some specific contexts. However, excessive emphasis on liability as a source of positive duties can create two problems; first, liability focused approaches ignore contexts in which it is not possible to establish liability, and underestimates the difficulty of establishing responsibility for fulfilling positive duties when liability is disputed. That is, if Pogge's argument is accepted, in order to assign responsibility for the fulfilment of positive duties it must first be ascertained whether deprivations are the result of past failures to fulfil negative duties, and second, the agents responsible for failing to fulfil those duties must be identified, and the extent of their liability determined. As such, reliance on liability as an indicator for responsibility adds theoretical and empirical complexity to the already complex problem of establishing responsibility for fulfilling positive duties. This additional complexity obscures the importance of positive duties, risks presenting them

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[1] As I argue in chapter four, liability is valuable when analysing the extent of duties to right holders, and when attempting to assign responsibility to appropriate agents. However, liability alone is not capable of justifying the full range of duties demanded by rights, as I also argue in chapter four.

as being of secondary concern to the fulfilment of negative duties, and makes it harder to establish the extent of any positive duties in a given context. Such issues reduce the clarity, and utility, of liability focused models.[1]

Secondly, given that in at least some cases severe harm can occur without failures of negative duties, deriving positive duties entirely from negative duties would ignore the needs of those harmed by factors beyond agent control. Such factors can impose deprivations which are just as harmful as agent directed harms, and thus pose a significant threat to the ability to actually enjoy the substances of rights. For example, while the effects of natural disasters are affected by the distribution of social resources (Callaghan et al. 2007; Neumayer & Plümper 2007), many harms caused by natural disasters are not the fault of any given agent, meaning that liability for them cannot be established (Cook et al. 2008, p.168). As such, a liability focused model would not provide adequate social guarantees of the actual enjoyment of rights, since the ability to enjoy the substances of rights could be removed by agent independent factors. As such, liability focused approaches fail to fulfil two aspects of Shue’s definition of rights.[2]

It might reasonably be objected that while liability alone does not provide a justification for positive duties in all contexts, Pogge's model can be interpreted as being one aspect of a wider account of rights and duties which

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[1] This issue is explored in more detail in a forthcoming paper (West-Oram Forthcoming).

[2] I discuss the issue of agent independent threats to health in chapters three and four, where I also discuss examples of agent independent deprivations of health and the difficulties they present for liability focused models of justice.

does not preclude other justifications for positive obligations to right holders. However, this argument only shows that liability focused approaches to positive duties should be considered as part of a wider model. Since the basic rights model can accommodate liability based justifications for positive duties[1] while also providing a justification for positive duties when liability is not present, Shue's approach to positive duties has greater utility than liability focused approaches. Further, the basic rights model provides a more comprehensive statement of the requirements of justice than those approaches which attempt to justify positive duties with reference to negative duties. As such, it provides better guarantees of the ability to actually enjoy the substances of rights by responding to the existence of contexts in which liability is not a factor.

The second benefit resulting from the breadth of Shue's triumvirate of duties is its ability to accommodate duties owed by both individual and corporate agents. In the global context, the ability of individual agents to help or hinder the enjoyment of rights is relatively minor, at least when considered in isolation from the cumulative impact of the actions of large groups of people.[2] In contrast, the impacts of the actions of governments and

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[1] As I discuss in chapter four.

[2] For example, person *A* who is a citizen of a wealthy country may on her own have only a limited ability to directly benefit her counterpart *B*, who is a citizen of a poor country. While *A* might be able to contribute funds to the provision of services which will enable *B* to enjoy his rights, the effect that *A* is able to achieve on her own is likely to be relatively small. Conversely, *A* also has a relatively small ability to cause harm or deprivation to *B* directly. She can consume recklessly, and refuse to contribute funds which will support *B*'s ability to enjoy his rights, but like her ability to help *B*, *A*'s ability to harm is indirect, and minor in itself (at least when considering agents in different geographical locations) (Lichtenberg 2010, p.564). It should be recognised however, that the impact of *A*'s behaviour in conjunction with the behaviours of other people, can generate significant

corporations are often direct and their effects can often exceed even the cumulative impacts of the actions of groups of individual agents. As such, it is necessary for any theory of global justice to account for the duties held by both individual and corporate agents and to recognise the differing levels of power held by each if it is to provide adequate guarantees against deprivations of the substances of rights.[1] Shue acknowledges this difference in capability, and argues that corporate agents as well as individuals must fulfil the demands of the triumvirate of duty. For example, he argues that governments of wealthy countries must avoid supporting authoritarian governments which engage in 'systematic deprivations of subsistence [and other] rights' (1980, pp.161, 164).[2] Similarly, he argues that U.S. based corporations stop the 'thwarting of U.S. policies towards basic rights' (1980, p.170).[3]

Importantly, while the same three duties apply to all agents, they can be interpreted as imposing different obligations on different types of agent. For example, a person with a low income may have a duty to contribute a small proportion of that income to the cost of providing a system of laws and the

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assistance or deprivation for *B*. Alone, *A* is relatively powerless, but when her actions are aggregated with those of other people, they can have significant consequences.

[1] This presents another problem for Pogge's model, since in some cases the agents responsible for harms caused by their failing to fulfil their negative duties may lack the ability to compensate or aid those they have harmed. In such contexts, right holders may not receive the aid they are owed because of the inability of their persecutor to provide it to them. I discuss this problem in more detail in chapter four.

[2] This is a point developed more thoroughly by, amongst others, Thomas Pogge (Pogge 2008c; Pogge 2008b).

[3] Shue's discussion of these issues is not included in the second edition of *Basic Rights*, though they are central concerns in the latter part of the first edition (Shue 1980, pp.156–170). However, he does offer an example of the impacts of governmental and corporate economic actions in both editions of *Basic Rights* which refer to the same point (Shue 1996, pp.42–44).

means to enforce them. Correlatively, her wealthier counterpart may have a duty to contribute a greater proportion, and their government would have a duty to allocate those funds and actually provide the appropriate systems. Collectively, these actions would contribute to the fulfilment of the duty to protect from deprivation by funding, constructing, and administering the systems necessary to provide protection to right holders.[1]

Shue also considers the kinds of action that would be required in order to prevent the significant power of corporate agents from being used to cause deprivations, and acknowledges the importance of governmental action in preserving the basic rights (1980, pp.55–56, 155, 170).[2] Further, there are a broad number of ways in which individuals can indirectly contribute to the provision of health care services to right holders. The basic rights model therefore explicitly recognises the importance of the role of different types of agents in fulfilling the basic rights while the triumvirate of duties can account for a wide range of obligatory behaviours required from different types of agent.

The breadth of the triumvirate of duty enables the basic rights model to respond to the complexity of the demands of the basic rights, and thus provide firmer guarantees that rights will be protected. Since the threats to

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[1] I discuss the way in which the relative capability of different agents can aid in determining the extent of their specific duties in more detail in chapters three and four.

[2] Both duties are held by both types of agent (as well as the duty to aid), since both types of agent can cause harm by failing to meet the demands of the duty to avoid depriving, and both can contribute to the fulfilment of the duty to protect, though in different ways. For example, corporate agents may contribute funds to the provision of protective services in the same way as individuals, while governmental agents may be required to administer those funds, and provide appropriate protective services.

human wellbeing at the global level are so large, the duties which can reasonably be held by individuals, and the behaviours that they demand, cannot adequately respond to them.[1] Therefore, preservation of the basic rights requires that we acknowledge both the significant power to act enjoyed by corporate agents, as well as their duties. Since Shue explicitly acknowledges the importance of the duties owed by corporate and governmental agents, and since the triumvirate of duty is broad enough in scope to accommodate them, the basic rights model is able to effectively respond to the requirements of the basic rights.

In the following section I discuss the benefit of specifying certain goods as the objects of moral rights. In doing so I argue that the basic rights approach offers a substantive account of value thus provides a clear account of the demands of justice. I also argue that the basic rights model respects reasonable differences in perspectives on the good life, whilst also avoiding problems of excessive theoretical breadth.

1.10c –Clarity of Objective

In this section I argue that in identifying a narrow set of goods to which all persons are entitled, the basic rights model specifies clear objectives to be fulfilled by duty bearers yet avoids providing either an overly narrow, or

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[1] It is unreasonable for example to demand that individual agents take personal responsibility for responding to global threats of pandemic disease. A response to such threats is only possible through collective action, itself enabled by recognition of the importance of corporate agency. Importantly however, this is not to suggest that corporate agents should be seen as entities with moral rights, but merely that corporate agencies do act with intention, and that the consequences of those actions can have far reaching consequences.

overly broad statement of what qualifies as a decent life. To make this claim I first outline how, by identifying specific goods to which people are entitled, substantive accounts of justice provide clear objectives for duty bearers. Second, I note that despite the clarity of objective that substantive accounts of justice can provide, they can be accused of paternalism, or of value-imperialism. Third, I note one response to this claim. Fourth, I provide two reasons why the basic rights model minimises the extent to which it is vulnerable to the paternalism, or value-imperialism, claim. Finally, I argue that the basic rights model avoids the imposition of either an excessively narrow, or excessively broad, view of the good, while presenting a clear set of objectives for duty bearers to work towards.

First, substantive accounts of justice specify goods to which it is claimed all persons are entitled, and which are claimed to be necessary for any decent life. As a result, models which identify specific goods, such as Martha Nussbaum’s list of ten core capabilities (2003, pp.41–42), or the basic rights model, also provide a clear set of objectives for duty bearers to strive towards. That is, in stating that all persons have rights to the capability of ‘play’ for example (Nussbaum 2003, pp.41–42), Nussbaum is also asserting that some persons have responsibilities to ensure that all persons are able to enjoy their capability to play. In this way, justice approaches which provide detailed lists of fundamental goods provide clear objectives for duty bearers to aim for.

One possible consequence of models which identify specific entitlements is that they may be thought to claim, by implication, that all persons should want the things which are specified by the model (Shue 1996, p.19). As a consequence of the value judgement implicit to lists of 'basic rights' or 'core capabilities', substantive accounts of justice can be accused of paternalism, or value or cultural imperialism (Barr 2002; Pagden 2003, pp.171–172; Teik 2003).[1] Such approaches to justice might be accused of failing to describe a universal set of values, and rather to reflect only a specific view of what is required for a decent life which is incompatible with other cultural or ethical traditions (Perry 1997; An-Na'im & Henkin 2000, p.96).[2] As such, substantive accounts of justice may be accused of infringing upon rights to freedom of conscience by demanding that all persons contribute to certain goods to which they may reasonably object. For example, Martha Nussbaum's list of ten core capabilities (2003, pp.41–42) has been criticised for favouring a specific view of what the good life is or should be, and has been argued to not be as universally acceptable as is claimed (Jaggar 2006, p.317).[3]

In contrast, Nussbaum has noted that Amartya Sen has consistently avoided suggesting a comprehensive list of core capabilities (Sen 1999, p.75;

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[1] In chapter five I discuss the objection from cultural imperialism in more detail, and note Sen's rejection of the dichotomy of western and non-western cultural traditions (1997; 1999, pp.231–232). I also note that even if this dichotomy is accepted, the basic right to health care is compatible with all value traditions.

[2] This has been described as 'moral neo-colonialism' (Widdows 2007, p.305).

[3] Though it is important to note that Jaggar's objection to Nussbaum's core capabilities is based on the methods of reasoning used to reach them and not on the capabilities selected themselves (2006, p.320). Therefore, it can be argued that while Jaggar's argument is correct, this does not in itself disprove Nussbaum's argument, it may merely show it to be illiberal or paternalistic, which as has been noted elsewhere is not necessarily a fatal criticism (Widdows & West-Oram 2013a).

Nussbaum 2003, p.44). This is largely because of the value he ascribes to public deliberation, and to the rapidly changing nature of global circumstances (Sen 2004, pp.77–78). Nussbaum notes that Sen's argument for the importance of public deliberation, and on local preferences, appears to be an attempt to avoid accusations of illiberalism, and to respect different cultural values. However, Nussbaum questions Sen's position, noting that while he does not go so far as to say 'I'm for justice, but any conception of justice anyone comes up with is all right with me' (2003, pp.47–48), his reasons for avoiding a definitive capabilities list are unclear, and risk being interpreted as tacitly condoning misogyny or other violations of human rights.

Where Sen's version of the capability approach provides no explicit list of capabilities, and Nussbaum offers an extensive list, the basic rights approach offers a 'quite short' list of rights (Shue 1996, p.29), which individually guarantee only minimal entitlements to certain essential goods. As such, the basic rights model covers the middle ground between non-prescriptive accounts of justice such as that provided by Sen, and more substantive accounts of the demands of justice like that provided by Nussbaum. The basic rights model is therefore able to avoid the problem, associated with non-prescriptive approaches to justice, of appearing to tacitly condone unjust practices as long as they are 'chosen' by their community (Nussbaum 2003, p.48). It also minimises the extent, because of the limited nature of the guarantees offered by the basic rights model, to which the paternalism or value imperialism objection applies (Jaggar 2006, p.320).

Shue argues for the importance of the basic rights because he takes them to be necessary for enjoyment of any decent life and any other rights (1996, p.xi).[1] In this way, the goods specified by Shue share a similarity with the essential capabilities identified by Nussbaum. As such, while Shue's list may be shorter than that proposed by Nussbaum, it could be thought to be vulnerable to the same objection from paternalism. However, the more limited nature of the goods proposed by Shue minimise the force of this claim, as I argue below.

There are two main reason why the basic rights model is less vulnerable to objections from paternalism than more broadly substantive approaches; first, although the basic rights model does specify a set of goods and rights necessary for enjoyment of a decent life, the rights which Shue proposes are an attempt to provide exactly, and only, what is required for any kind of life. Second, because of the limited number of basic rights, and their focus on basic necessities, the extent of the duties correlating to them is correspondingly small. For these reasons, the basic rights model minimises the extent to which it imposes a particular view of the good on reluctant duty bearers, whilst also providing a definitive account of the minimum moral demands of distributive justice. I discuss these points in more detail below.

First, the goods defined by Shue as the substances of basic rights are those which are 'made essential by the very concept of a right' (1996, p.31), as I

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[1] As noted above, Shue also argues that the basic rights are so important that the denial of them is something 'which no self-respecting person can reasonably be expected to accept' (1996, p.19).

discussed in section three of this chapter. Since the basic rights are those which are necessary for any rights, the value of the basic rights is not restricted to 'western' cultural paradigms, since they are focused only on ensuring that persons are protected from major threats to their physical wellbeing, and their ability to enjoy any rights, or social goods,[1] and any decent life. Further, it is implausible to suggest that entitlements to physical safety or economic security are things to which any person could reasonably object to being entitled,[2] even independently of the instrumental value of these rights.[3] Rights to political participation are more controversial, as Shue acknowledges (1996, pp.65–70), yet are vital if persons are to be protected from government sponsored violence which can make it impossible for them to enjoy other rights (Shue 1996, pp.74–80). As such, while the basic rights model does propose a definite set of rights, the entitlements it proposes are less extensive than those proposed by Nussbaum, and entitle right holders only to those goods which are logically necessary for the enjoyment of any rights, as discussed in previous sections.

Second, there are very few basic rights, and as noted above they focus exclusively on guaranteeing right holders access only to those goods which

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[1] As argued above, a right to cultural expression, even when that culture rejects rights, is not possible in the absence of rights to security, subsistence, liberty, and health care. Therefore, to assert any rights, even those incompatible with 'western' values, is to assert these basic rights. However, in chapter four, I argue that the 'cultural incompatibility' argument for the rejection of rights is not well grounded (Polisi 2004; Holomisa 2005; Cherif 2010).

[2] However, it might be objected that while the basic rights themselves are not controversial, the existence and extent of duties corresponding to these rights is objectionable, since duty bearers may be required to contribute to the provision of goods of they disapprove. I discuss this claim below.

[3] Indeed, as noted above, Rawls acknowledges the importance of the subsistence rights described by Shue, and argues that they are essential for liberty rights (1999b, p.65).

are absolutely essential for the enjoyment of all other rights (Shue 1996, pp.29–34). Therefore, while the duties corresponding to the basic rights are demanding, they are also limited in scope and require duty bearers to perform only those actions which are absolutely necessary to ensure that right holders are able to enjoy a very minimal set of entitlements.[1] Therefore, the basic rights model minimises the demands placed on duty bearers and thus avoids requiring them to contribute more than absolutely necessary to the cost of goods of which they possibly disapprove. In this way, Shue's model, while specifying a substantive set of goods and rights respects the personal choices and preferences of individual agents with different preferences and beliefs as far as is compatible with providing an acceptable minimal welfare standard for all persons.

The basic rights model does identify a specific set of goods to which all persons are entitled. In doing so, it specifies a particular view of the good, and is vulnerable to claims of paternalism, or 'moral neo-colonialism' (Widdows 2007, p.305). However, as argued above, the extent of the rights the model describes is limited in scope, and entails only limited duties. Therefore, while the basic rights model can be described as paternalistic, it is paternalistic in a very limited way, and only to the extent necessary to ensure essential rights to all people. As such, the basic rights model avoids the

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[1] Further, as discussed above, in some contexts many rights will require only restraint from duty bearers, rather than demanding positive action. This means that the duties correlating to the basic rights are less demanding than may be feared. However, this is also true of alternative accounts of the range of minimum human entitlements, though the smaller range proposed by Shue means that there are likely to be fewer instances where positive action is required by the basic rights model than for Nussbaum's list of core capabilities, for example.

problem of ‘excessive theoretical breadth’ more effectively than models like Sen’s (2004, pp.74–78) which fail to specify core goods. Further, in specifying particular goods to which all persons are entitled, the model also provides a clear statement of what must be achieved in order to fulfil the demands of justice, meaning the basic rights model enjoys clarity of objective. The model also avoids the more extensive claims made by broader models such as that offered by Nussbaum (2003, pp.41–42), and thus charts an effective middle course between excessively broad models which risk ignoring important sources of injustice and harm, and the ‘value-intrusiveness’ of more comprehensively substantive approaches.

In the following section I summarise the three advantages of the basic rights model, and argue that because of its theoretical clarity and broad scope, it provides a clear, direct way of theorising about global justice which provides effective guarantees of rights to right holders.

1.10d – Summarising the Benefits of the Basic Rights Model

In the preceding sections I set out three theoretical features of the basic rights model which endow it with significant clarity and breadth in three important areas. Firstly, I argued that Shue’s argument for the interrelatedness of the basic rights foregrounds the importance of rights which are sometimes neglected by ‘North Atlantic nations’ (Shue 1996, p.65). By explaining the interrelatedness of the basic rights, Shue highlights the importance of subsistence rights, and thus provides a clear justification for the existence of a basic right to subsistence. By doing so, the basic rights model is also able to respond to a wider range of harms than models which provide less explicit arguments for the importance of certain fundamental goods. As such, it is better suited to meeting the demands of global justice and promoting individual welfare because it provides a clearer statement, and justification of, a broader set of important welfare goods.

Secondly, I argued that the comprehensiveness of Shue's triumvirate of duties clarifies the nature of the duties correlating to rights, and accounts for differences in the extent of the duties owed by different right holders. As such, it provides better guarantees of the adequate enjoyment of the substances of rights than models which provide less broad accounts of duty. I also argued that by rejecting the distinction between positive and negative rights, Shue provides a clear account of the range of duties corresponding to rights, and thus ensure better protection for the goods necessary for living a decent life. As such, the basic rights model accounts for a broad range of considerations which may be missed by approaches which accept the distinction between positive and negative rights. I also argued that an additional consequence of the breadth of Shue's triumvirate of duties was that it can accommodate a range of duties owed by different duty bearers. This is because each of the duties described in Shue's triumvirate of duty is phrased in very general terms and can therefore accommodate a range of specific behaviours required by different types of agent.

Third, I argued that the substantive account of the goods necessary for the enjoyment of a decent life provided by the basic rights model provides significant clarity in objective, while avoiding the excessive ‘value-intrusiveness’ which can accompany more substantive models. This is because Shue’s account of the importance of the basic rights is based on an extremely minimal account of human entitlements. As such it does not specify a particular kind of decent life that all persons should want to live, but rather focuses on enabling right holders’ ability to live any decent life. As such, while the model enjoys the focus, comprehensiveness, and responsiveness of a more actively substantive account of the requirements of justice, it does so in an unobtrusive manner which is compatible with accounts, like that provided by Rawls, which may seem more unrestrictedly liberal. Therefore, the model avoids much of the force of the paternalism argument whilst also providing a clear statement of the demands of justice, in the form of its list of basic goods.

The advantages I have discussed in the previous sections all relate to the breadth and clarity of the basic rights model. The breadth of the model means that it is able to provide better protection against a wider range of threats to wellbeing than alternative approaches. As such, the basic rights model is able to more adequately guarantee a right holder’s ability to live any decent life, while the clarity of the model provides the means to explain and defend this breadth. Clarity in justification, obligation, and objective also makes it easier to theorise about aspects of the model which are not fully explained, such as the importance of health care for a decent life. In addition, this clarity makes it simpler to establish the specific requirements of the basic rights model and to develop a precise account of the behaviours demanded of different agents by the triumvirate model of duty. Therefore, in addition to providing a clear justification for the importance of certain goods, and explaining which persons are responsible for fulfilling which duties, the basic rights model also provides a strong foundation upon which to construct a supplementary argument for the importance of a right to health care.

1.11 – Summary

My goal in this chapter was to set out the structure of the basic rights model, and list its advantages as a method for theorising about the demands of global justice. In doing so, I explained Shue's definition of basic rights, and how they are differentiated from non-basic moral rights. In addition, I noted the significant absence of a comprehensive right to health care from the basic rights model, and argued that access to at least basic health care services is essential for enjoyment of any other rights. As such, it fulfils what I have termed the necessity criterion and thus qualifies as a distinct basic right. I also argued that to provide adequate guarantees against the standard threats which threaten the ability to live a decent life the basic rights model must include an additional basic right to health care.

I have not in this chapter attempted to provide a complete, or even a general account of what the basic right to health care requires. Instead I have merely argued that a right to at least basic health care services is a prerequisite for the enjoyment of all other rights, and that as such it qualifies as a basic right. In the following chapters I discuss in more detail the requirements of each of the duties demanded by the basic rights in the context of health care. In doing so, I demonstrate in more detail the appropriateness of acknowledging health care as a distinct basic right, and its compatibility with the basic rights model. My goal in analysing each duty is to demonstrate how the provision of certain basic health care services could be accommodated by the theoretical constraints of Shue’s triumvirate of duties.

In each of the three following chapters I discuss one of the duties described by Shue. In the case of the duties to avoid depriving and to protect from deprivation I refer to one central example for illustrative and discursive purposes. In the case of the duty to avoid depriving I discuss the issue of the accessibility of essential medicine generated by the provisions of the Trade Related Aspects of Intellectual Property Rights (TRIPS) regime (World Trade Organization 1994). When discussing the duty to protect I consider the global implications of the spread of infectious disease, and the ways in which providing protection from such diseases may be achieved. In the chapter on the duty to aid the deprived I move from discussing one main example, to consideration of a range of cases, and analysis of the ways in which the provision of aid might be prioritised and allocated. The structural shift in this chapter is partly due to the complexity of the duty to aid and of illustrating with examples a wide enough range of potential aid scenarios. This approach also provides an opportunity to suggest a method for deciding between competing cases, something which is important in any theorising about distributive justice.

In chapter five I discuss four categories of potential objection to my argument. My goal in consolidating these objections into one chapter is to enable me to first outline the whole of my argument for health care as a basic right before demonstrating its resilience in the face of these likely objections. In doing so, I aim to demonstrate the suitability of acknowledging health care as the substance of a basic right, and the effectiveness of treating it as such when discussing questions of global justice.[1] Having made this argument, I conclude this thesis in chapter six with a summary of my argument for a basic right to health care.

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[1] Withholding discussion of these objections until the fifth chapter of this thesis means that the reader must to an extent accept the basic rights model on faith until a further defence is provided. I therefore thank the reader for their patience in this matter.

CHAPTER TWO

THE DUTY TO AVOID DEPRIVING: ‘NEUTRAL’ BEHAVIOUR AND THE BASIC RIGHT TO HEALTH CARE

> *Deprivations of health can be caused not only by malicious action, but also by negligence or the failure to adequately respect the rights and interests of other persons. In this chapter I set out the requirements of the duty to avoid depriving as it applies to the basic right to health care, and explain what the duty requires of duty bearers. To do so, I consider one main example, the Trade Related Aspects of Intellectual Property Rights (TRIPS) Regime, which I argue represents a failure on the part of many agents to fulfil their duties to avoid depriving.*

In the previous chapter I outlined Henry Shue’s model of basic rights, and argued that access to health care is of sufficient importance to qualify as the substance of a distinct basic right. I also argued for the value and utility of Shue’s basic rights model as a framework with which to theorise about global justice, and the welfare and entitlements of persons. In doing so, I outlined Shue’s triumvirate of duties which, he argues, covers the essential requirements for enabling right holders to enjoy the substances of their basic rights. In this and the following two chapters I examine the three duties in more detail, starting here with the duty to avoid depriving. My goal in these chapters is to demonstrate how the model of duties described by Shue provides an outline of the demands of global health care justice, and thus how the duties apply to the basic right to health care. In addition, I aim to show the significance of deprivations of health, demonstrate how the basic right to health care may be fulfilled, and identify the agents responsible for doing so. In discussing the requirements of each duty I refer to a number of examples, and suggest ways in which the duties can be fulfilled.

In this chapter I argue that the duty to avoid depriving requires more of duty bearers than mere restraint in the face of opportunities to harm. I argue that in the health care context, fulfilment of the duty will require duty bearers to fulfil a broad range of behavioural requirements which require varying levels of commitment and obligation. To achieve this goal I first argue that the duty to avoid depriving requires a broad range of behaviours from duty bearers, and define and explain these behaviours. Second, I outline the key points and history of the main example for this chapter, the Trade Related Aspects of Intellectual Property Rights (TRIPS) regime (World Trade Organization 1994), and identify the deprivations which it causes. Third, I consider deontological and consequentialist arguments for TRIPS and argue that neither approach offers a successful defence of the regime in light of the deprivations it causes. Fourth, and with reference to the weakness of the justifications offered for TRIPS, I argue that the regime is far from morally neutral and does in fact serve to deprive vulnerable persons of the substances of at least one of their basic rights. As such, I argue that TRIPS represents a failure on the part its authors, advocates, and in some cases beneficiaries, to fulfil the demands of their duties to avoid depriving. Fifth, I suggest two additional examples of economic practices which violate the impartiality criterion in order to demonstrate the wider applicability of my arguments about the duty to avoid depriving. Sixth, I briefly discuss some alternative approaches to incentivising the production of new pharmaceutical products.

While the TRIPS regime is my main example, my goal is not merely to show that it fails to meet the demands of the duty to avoid depriving, but rather to explain the features and requirements of the duty to avoid depriving in the health care context through analysis of one major case study, and in doing so demonstrate how Shue's first duty applies to the basic right to health care. To do so, I first explain how the duty to avoid depriving entails the fulfilment of three distinct behavioural requirements.

2.1 – Different Types of Depriving Behaviour and How They May be Avoided

In this section I argue that adequate fulfilment of the duty to avoid depriving is a complex task, and requires duty bearers to avoid three distinct types of behaviour. To make this argument I first highlight examples of depriving behaviours identified by other theorists, and note that deprivations of health are not caused solely by deliberately malicious action. Second, I suggest three categories of behaviour which violate the duty to avoid depriving, before explaining each category in turn.

In describing possible sources of deprivation Shue discusses the detrimental impacts that the economic practices of wealthy individuals, corporations and countries can have on the poor, even when such practices are not intended to cause harm (1996, pp.41–43). Similar claims are also made by Thomas Pogge

(2008c, pp.118–121) and Gillian Brock (2009, p.125), when they each discuss the ways in which existing structures, be they legal, political or economic, allow, and more importantly encourage, significant harms to be caused to vulnerable persons. Judith Lichtenberg has also noted that ‘that our most humdrum activities may harm people in myriad ways we have never thought about before’ and that the ill-considered consumption of certain resources may have high costs for vulnerable persons (2010, pp.558–559).[1] Harmful deprivations can also be caused by the deliberate action of malicious agents, or by the creation of explicitly discriminatory laws.

Lichtenberg argues that fulfilling our duties to other persons cannot be thought to be a matter merely of adhering to the demand ‘[d]on’t kill people, don’t rape them, don’t attack them, don’t rob them’ (2010, p.558). Lichtenberg’s arguments about the ‘new harms’ (2010, p.557) can be applied to the duty to avoid depriving to highlight three categories of agent behaviours which violate the duty; first, malevolent actions, a category which includes the harms mentioned by Lichtenberg; secondly, negligent actions, which include failure to take proper notice of the likely consequences of behaviour (Lichtenberg 2010, p.563); finally, partial actions are those which treat the interests of one individual or group as of lesser value or importance than those of preferred individuals or groups (Lichtenberg 2010, pp.563–

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[1] See also (Murtaugh & Schlax 2009; West-Oram & Widdows 2012).

564).[1] Fulfilment of the duty to avoid depriving requires duty bearers to avoid the performance of each of these three kinds of behaviour. As such, I suggest that there are three correlative requirements of the duty to avoid depriving which can be termed the non-malevolence, conscientiousness (or non-negligence), and impartiality conditions, each of which I discuss in more detail below.

These conditions are not part of Shue's definition of the duty to avoid depriving, but are derived instead from Lichtenberg's commentary, the ways in which harm may be inflicted on persons, and from existing philosophical and legal norms. For example, the moral significance of negligently caused deprivations of health is demonstrated by the existence of legal norms of compensation for liability for harms caused, even when those harms are not the result of deliberately malicious action (Calabresi 1975; Cane 1982; Cripps 1986; Coleman 1992, p.378).[2] Similarly, impartial deliberation between the interests of agents is a fundamental aspect of much philosophical thought. It is arguably central to Rawls' justification for the original position (1999a, pp.16–18), and its importance is implied by the categorical imperative (Kant 1998, AK 4: 421).[3] Therefore, I suggest these conditions as a way of

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[1] For example, the provision of a certain benefit to group *A* knowing that such provision will inevitably generate deprivation for group *B* and treating that deprivation as inconsequential or unimportant.

[2] I argue for the importance of negligence and liability in more detail in chapter four.

[3] See also, (Henberg 1978, p.715; Becker 1991, p.698; Sen 2002, p.445; Lucy 2005, pp.30–31)

foregrounding types of depriving actions which may not be immediately obvious, and as a way of clarifying the practical requirements of the duty.[1]

2.1a – Non-Malevolence

The first of the requirements of the duty to avoid depriving is the demand for non-malevolence from duty bearers. This is the simplest of the three requirements of the duty to avoid depriving since it focuses exclusively on restraint in the face of opportunities to deliberately cause deprivation. The kinds of action which this requirement prohibits are things like murder, rape and theft (Lichtenberg 2010, p.558). The kinds of action which this requirement addresses will often also fail the impartiality condition, since malevolent action rejects the importance of the interests of the victim. However, there are actions which are partial, yet which are non-malevolent. For instance, a malevolent action is one performed with the intention and objective of causing harm to a victim. In contrast, as I discuss in more detail below, a partial action is one which is performed in order to aid a beneficiary, which will also cause harm to a third party, and which is performed with full knowledge of that harm, yet without ascribing moral importance to it.

The non-malevolence requirement is perhaps the easiest to fulfil. However, while non-malevolence is certainly important to the duty to avoid depriving, it is not the duty's only requirement. The conscientiousness requirement of

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[1] Later in this chapter I offer a detailed analysis of the way in which the authors, advocates and beneficiaries of the TRIPS regime (World Trade Organization 1994) fail to fulfil the duty to avoid depriving by violating what I describe as the impartiality requirement of the duty to avoid depriving.

the duty to avoid depriving is more complex than the non-malevolence condition, and requires more in the way of active engagement from duty bearers.

2.1b – Conscientiousness

The second demand of the duty to avoid depriving is the conscientiousness, or non-negligence, requirement which focuses on those deprivations not caused deliberately as a result of malicious action, but on those caused by reckless behaviour or negligence. This requirement obliges duty bearers to actively consider the likely consequences of their actions, and take reasonable precautions against the occurrence of likely harms. This can include merely being careful about how one interacts with one's environment and community. Lichtenberg argues for example, that

> '[h]aving harmed a person always provides a reason to rectify her plight over and above any other reasons one has. Think of the proverbial drowning child in the pond. Most people agree that the bystander ought to wade in to save the child. Yet few would deny that the reason to intervene intensifies if the bystander is no mere bystander but has pushed the child into the water. Even if the act is not intentional but accidental, we are strongly inclined to believe the agent has a greater responsibility to act than does the innocent bystander.'

(2010, p.563)

Deprivations caused by negligent behaviour might also include injury as a result of dangerous or intoxicated driving (Little 1972, p.950), or failures to adhere to safety regulations about the use or disposal of hazardous chemicals (Sans et al. 1995; Wesseling et al. 2005). As such, these kinds of deprivations might be thought of as the accidental or aberrant consequences of reckless behaviour or negligent oversight (Oppenheimer 1993, p.899). The significance of negligence as a source of deprivations of health is demonstrated by the existence of legal norms which penalise those responsible for causing such harms. For example, Freeman notes that

> ‘Criminal liability is imposed for the failure to aid within special relationships such as those between parents and their small children, husbands and wives, or employers and their employees. Criminal liability is also imposed for neglect of professional duties, as in the case of physicians or nurses and their patients, lifeguards and the swimmers they are paid to watch, and railroad gatemen and approaching motorists.’

(1994, p.1456)

Importantly, deprivations caused by negligence are distinguished from those caused by malicious action in that they are not the result of an intention to harm, but instead are a side effect of actions which should have been performed more carefully, or not at all.[1] That is, these deprivations would not

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[1] It is worth noting however, that Bonnie Steinbock has argued that deaths caused by drunk drivers are not cases of negligence, but of murder (1985, p.278). While Steinbock

have happened had the responsible agent acted more carefully, or been considerate of the consequences of their actions. The conscientiousness requirement obliges duty bearers to consider the potential consequences of their actions, avoid endangering other persons, and where a given action is justifiable, other things being equal, to take appropriate measures to minimise its associated risks to others.

2.1c – Impartiality

The third behavioural requirement of the duty to avoid depriving is that duty bearers must act with impartiality towards the interests of all persons and not prioritise the non-basic interests of preferred groups over the basic rights of non-preferred groups. As noted above, impartiality of action is a central consideration to much ethical thought, and is endorsed by a range of thinkers (Kant 1998, p.AK 4: 421; Rawls 1999a, pp.16–18; Singer 2008, p.12). It is however, a concept that is not without debate, as I discuss below. In this section I explain the importance of the impartiality requirement of the duty to avoid depriving. To do so I first explain what distinguishes partial and negligent actions and define what is meant by partial actions. Second, I set out what is required by the impartiality condition. Third, I examine one objection to impartiality as a moral principle, and argue that while it may carry weight against other uses of the term, it does not invalidate impartiality in the way I use it here.

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may be correct, I do not consider this further here, since it would merely shift the example from being one of negligence to one of malevolence.

First then, partial actions are distinguished from negligent actions in that the latter is concerned with deprivations which occur because of a failure to adequately appreciate the risk of deprivation occurring - they underestimate the *likelihood* that harm will occur. Conversely, the former category of action undervalues the importance of the people that the deprivations will affect. That is, partial actions accept the risk that deprivation will occur, but treat as unimportant the interests of the victims.[1] Richard B. Stewart has called this the '*problem of disregard'* (2014, p.211). In this way, while partial actions are in a sense negligent, since they ignore the importance of the rights of certain persons, they are also different to negligent actions with regard to that which they neglect.

Second, the impartiality requirement of the duty to avoid depriving requires that duty bearers not cause, or allow to be caused, significant deprivations to members of non-preferred groups in order to convey less significant benefits to others. This kind of behaviour includes the establishment of rules which deny right holders access to the substance of basic rights in order to generate financial benefits to others, the most obvious example of this kind of action being slavery (Quirk 2006; Lichtenberg 2010, pp.563–564). In such contexts the needs and rights of one group are treated as of less importance than the desires or preferences of a preferred group.[2] Importantly, the kinds of actions

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[1] This is the category of actions with which Pogge (2008c, pp.118–121) and Brock (2009, p.125) are concerned.

[2] This does not refer to cases where the needs of two equally vulnerable groups cannot both be met. The impartiality condition is intended as a requirement to ensure that the moral status of all relevant stakeholders is considered equally in the performance of potentially depriving behaviours. In chapter four I propose a method for distinguishing

which qualify as partial are not focused on harming others as their central goals, and they are different to those which are classified as negligent as discussed in the previous section. Rather, they are the kinds of actions which acknowledge the potential for deprivation to a specific individual or group as a side effect of the intended outcome of a specific action,[1] but which treat that deprivation as of lesser importance than the, potentially non-basic,[2] benefit to be gained by a second individual or group.

Third, the 'impartiality thesis' (Cottingham 1983, p.83) has been criticised on the grounds that it would require duty bearers to expend their resources on promoting the welfare of others if doing so would generate more overall welfare, even if doing so would be extremely costly for the duty bearer in question.[3] Cottingham argues that a demand for impartiality would require duty bearers to consider the interests of other agents as being equal to their own in all cases. In doing so he argues that this would require duty bearers to consider whether their resources could be used to more effectively promote the interests of others in all cases and to use them to do so if other persons would benefit more from doing so (Cottingham 1983, p.87). This would,

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between the more difficult kinds of case where available resources are insufficient to meet the equal needs of competing groups.

[1] Such actions are not however malevolent, because their primary goal is to serve the interests of a favoured party, rather than to cause harm to a non-favoured one. Any deprivations caused by partial action are therefore the result of ignoring the consequences of the action in question. In contrast malevolent actions are those which are intended to cause harm or deprivation as their primary objective.

[2] Non-basic benefits are those benefits which are not the substances of basic rights.

[3] This claim is similar to what Thomas Pogge describes as the 'jeopardy' argument against helping the global poor, in that both arguments are concerned with the excessive duties imposed on duty bearers (2008c, pp.7–10).

Cottingham argues impose unreasonable demands on duty bearers and therefore renders the impartiality thesis ‘untenable’ (1983, p.83).

While Cottingham’s argument raises a potential logical problem for brute impartiality as a general requirement of justice, it does not apply to my use of the term. Cottingham’s argument focuses on the consequences of omissions on the part of duty bearers – on their failures to provide aid to those who would benefit more from those resources. In contrast, I refer to impartiality as a way of evaluating actions, not omissions. As I argued above, the kind of partial *actions* I am concerned with are those where harm is inflicted on third parties in order to convey benefits to a preferred person or group. Therefore, my ‘impartiality thesis’ is not the same as that with which Cottingham is concerned. My argument criticises partial actions which *cause harm* as a result of prioritising the interests of a preferred group, the impartiality thesis Cottingham rejects, criticises actions which *do not help* other persons.

The impartiality requirement demands that the denial of the basic rights of one group is not treated as a means to confer disproportionate benefits on another.[1] This condition is intended to ensure that the moral status of all persons is not ignored or under-valued and thus to avoid depriving members of non-privileged groups as a result of the dismissal of their rights and interests. If a policy is enacted, or behaviour undertaken, which acknowledges

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[1] Disproportionate benefits are those where the gain to the beneficiary is greatly outweighed by the cost to the deprived third party. This will be most evident in cases where non-basic rights are prioritised over basic rights, but may also apply in contexts where one basic right is prioritised excessively, as I discuss in more detail below.

that deprivation is likely to be caused to a non-preferred group, but which treats this as irrelevant when compared to the benefit to be gained by another group, that policy or action has failed the impartiality condition.

2.1d – Non-malevolence, Conscientiousness, and Impartiality

In this section I first summarise the three behavioural requirements of the duty to avoid depriving. Second, I explain how responsibility for failures to fulfil these requirements is to be assigned. Third, I discuss the way in which the TRIPS regime represents a collective failure on the part of many duty bearers to fulfil their duties to avoid depriving. Finally, I explain my use of the TRIPS regime as the core example of this chapter.

The three requirements suggested above are a means to clarify the practical demands of the duty to avoid depriving and to highlight the fact that '[n]ot harming people turns out to be difficult and to require our undivided attention' (Lichtenberg 2010, p.558). Firstly, the non-malevolence requirement demands that agents not deliberately cause deprivation to specific individuals or groups when the deprivation suffered is the purpose of the action. Secondly, the conscientiousness requirement obliges duty bearers to acknowledge and account for risks to others that are associated with their non-malevolent, but negligent or careless, actions. This condition addresses those deprivations which occur as a side effect of other, potentially legitimate, behaviours. Thirdly, the impartiality condition requires that duty bearers treat the rights and interests of all persons with equal respect, and not act in ways that will cause deprivations to others as a result of the goal of benefiting third parties.

Fulfilment of the duty to avoid depriving is therefore a complex goal. Just as there are a number of agent-related ways in which deprivations may be caused, there are a corresponding number of ways in which duty bearers must act in order to avoid causing deprivation. As has been noted by many theorists, we live in an interconnected world, one in which the seemingly neutral actions of duty bearers can have a profound effect on the lives of distant others in a complex variety of different ways (Lichtenberg 2010, pp.557–558; Wenar 2008, pp.2–3; Brock 2009, p.125; Wisor 2012). A consequence of the variety of ways in which the duty to avoid depriving can be violated, is the corresponding complexity of assigning responsibility for such harms.[1]

All kinds of agents can fail to fulfil the duty to avoid depriving via violations of each of the three behavioural conditions; individual agents can be negligent of the risk they pose to others when driving and cause severe injury or death (Jacobs 1988; Husak 1994), while governments can pursue aggressive military or discriminatory policy which deliberately imposes harm to vulnerable groups of people (BBC News Online 2014). Similarly, corporate agents, instantiated by the collective will of their management teams and shareholders, can act negligently towards the risk their actions pose to others,

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[1] Importantly, such behaviours are sometimes codified into law, gaining a veneer of legitimacy, and can become seen as the legitimate practice of just institutions (Pogge 2008a; Pogge 2008c, pp.119–121; Wenar 2008).

and can fail to act impartially when lobbying for preferential treatment under the law, as is the case with TRIPS (Barton 2004).[1] Where actions are performed by individual agents, responsibility for the failure to fulfil the duty to avoid depriving is simple to assign. However, deprivations can also occur as a result of the collective behaviour of groups of persons. In such cases, responsibility for the harms caused is shared by more than one individual.

For example, the main case study in this chapter is the TRIPS regime, which demonstrates failure on the part of numerous duty bearers to meet the impartiality condition by failing to acknowledge the importance of impacts on rights to health care caused by limiting access to essential medicines. In this context, responsibility for the deprivations caused by TRIPS is shared amongst many individual agents. The agents who are most responsible for failing to fulfil the duty to avoid depriving are those who contributed to the development and emplacement of the TRIPS regime, and those who benefit directly from it. That is, the lobbyists who wrote and campaigned for the TRIPS regime, and the legislators (including governments and legal practitioners) who emplaced and enforce the regime are the duty bearers who are responsible for failing to live up to the duty to avoid depriving. In addition, pharmaceutical companies that exploit the provisions of the TRIPS regime can also be said to violate the duty to avoid depriving by pricing

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[1] Another example is the recent, successful, litigation by Hobby Lobby Inc. to opt out of the provision of contraceptive services which they deem immoral through their employee health insurance plans (Supreme Court of the United States 2014, p.60).

essential medicines out of the reach of vulnerable persons (since they are not forced to impose exclusionary prices on the drugs they develop).

While the TRIPS regime enables and legalises behaviour which deprives people as I discuss below, the goal of the regime is not the deliberate malevolent causation of harm or deprivation. Rather, the goal of TRIPS is to protect the intellectual property rights of pharmaceutical innovators and thus to promote innovation.[1] However, in protecting intellectual property rights, the authors of the TRIPS regime treat as of lesser significance the deprivations to many vulnerable right holders that the regime will cause and I argue that this breaches the duty to avoid depriving. In the following section I outline the provisions of the TRIPS regime.

2.2 - The TRIPS Regime

In this section I outline the provisions of the TRIPS regime and argue that the protections it provides to pharmaceutical innovators give them ‘enormous power to deprive’ right holders of access to essential medicines (Shue 1996, p.61).

The TRIPS regime provides time-limited monopolies to the producers of new intellectual property. For pharmaceutical products these monopolies, usually of around twenty years (Barton 2004, p.146),[2] but with a minimum of ten

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[1] However, as I discuss below, the TRIPS regime has only limited success in achieving this second goal.

[2] It should be noted that the monopolies to sell granted by TRIPS include the time taken for Research and Development, which reduces the length of time available for market exclusivity.

years (World Trade Organization 1994, p.331), are intended to protect the inventors of intellectual property, including novel chemical compounds,[1] from price competition by giving them sole rights to sell for the duration of their monopoly (Kabiraj 1994, p.2992). This monopoly power thereby gives pharmaceutical companies the ability to price new drugs at whichever level they choose in order to recoup the substantial costs of developing new medicines, free from market competition on price.

Since the cost of developing new medicines is so high (Adams & Brantner 2006, p.424), prices for new drugs upon their initial release are also generally extremely high (Viravaidya et al. 1996, p.11). Importantly however, an addition to TRIPS, the Doha declaration (World Trade Organization: Ministerial Conference, Fourth Session 2001), does allow for poor countries to issue compulsory licenses to manufacture generic versions of medicines under patent in order to combat imminent threats to public health, though the provisions are not simple to implement (Johnston & Wasunna 2007, p.18).[2] Further, the Doha declaration does not guarantee the same rights and privileges that the pre-TRIPS era permitted. Additionally, differential pricing agreements (another feature of the TRIPS agreement intended to recognise the needs of the global poor) are not widespread,[3] and compulsory licenses are frequently opposed, despite their legality under TRIPS (Outtersson & Light

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[1] It is worth noting that TRIPS also applies to other kinds of intellectual property, including works of art.

[2] They have also been criticised as being likely to impede future pharmaceutical research (Fisch 1994).

[3] However, differential pricing agreements are not without controversy, as discussed by Jorn Sonderholm (2010b, p.7).

2009, p.418). The TRIPS regime therefore gives great power to pharmaceutical innovators to exclude, through monopoly pricing, those without significant economic power.

As I discuss in more detail in the following sections, the TRIPS regime is predicated on the prioritisation of the intellectual property rights of pharmaceutical innovators. The basic rights to health care of consumers of pharmaceutical products are rarely considered, and little is done to protect or promote them (Flint & Payne 2013, pp.500–501). Consequently, TRIPS provides pharmaceutical innovators with significant power to prevent right holders from accessing medicines which they need to avoid major deprivations of their health, as I explain in more detail in the following section.

2.3 – Deprivations of Basic Essential Medicines Caused by TRIPS

In this section I argue that the TRIPS regime prevents right holders from accessing basic essential medicines.[1] The argument in this section is not intended to show that the TRIPS regime allows violations of the duty to avoid depriving. Rather, my goal in this section is merely to show that the basic right to health care entitles right holders to basic essential medicines, and that the TRIPS regime imposes barriers which prevent right holders from

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[1] I do not provide a definite list of basic essential medicines, but an indicative list of might be influenced by the World Health Organization’s essential medicines list (World Health Organization 2013).

enjoying the substances of this right.[1] In making this claim I first argue that the basic right to health care entitles right holders access to at least basic essential medicines. I argue this point with reference to the harms caused by deprivations of health and to Shue's argument for the importance of the basic right to liberty. Secondly, I suggest criteria for establishing which types of medicines would fall under this category. Third, I argue that the TRIPS regime prevents many vulnerable persons from being able to access basic essential medicines in both the short and long term.

Shue states that basic rights must ‘provide effective defenses against predictable remediable threats’ (1996, p.33).[2] While Shue is wary of imposing excessive demands on duty bearers he also specifies that ‘we have very little excuse for allowing so many poor people to die of malaria’ (1996, p.33), and notes that a decent life cannot be ‘fever-laden [and] parasite-ridden’ (1996, p.23).[3] Further, there are numerous diseases which are remediable, and which pose a significant threat to many people (L. B. Reichman 1996, p.175). Diseases like tuberculosis can make enjoyment of any rights impossible, and can limit the ability of right holders to live any decent life, and affect a very large proportion of the world’s population (Reichman 1997, pp.3–4).[4]

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[1] In the following sections I develop this argument to make the stronger claim that TRIPS does fail to fulfill the duty to avoid depriving. To do so, I examine two possible defences of the TRIPS regime, and argue that neither is sufficient to justify the inaccessibility of basic essential medicines caused by the regime.

[2] I discuss this point in more detail in the following chapter.

[3] Shue explicitly rejects the idea that there can be a right never to die or become seriously ill for example because such a right would be both impossible to guarantee and would commit duty bearers to impossible duties (1996, p.25).

[4] Other examples include malaria (889,000 deaths per year worldwide), diarrhoeal diseases (2,163,000 deaths per year worldwide), and HIV/AIDS (2,040,000 deaths per year worldwide) (Mathers et al. 2008, p.72).

Therefore, given that diseases like tuberculosis are treatable or at least preventable, and given that they can make enjoyment of other rights impossible, the basic right to health care must entitle right holders to at least some health interventions, including basic essential medicines, if it is to enable right holders to enjoy any rights.[1] Therefore, access to those interventions which provide reasonable guarantees against the deprivations these diseases threaten, is a necessary component of the basic right to health care. While it is arguably possible for a person to enjoy an entirely healthy life without enjoying access to effective medicines, that person would be both extremely lucky, and statistically improbable (if not actually impossible, given the inevitable deterioration in health which accompanies aging). Further, such a person would not enjoy their health in virtue of a right, but rather because of good fortune. I explain this point below.

The importance of access to basic essential medicines can be illustrated with an example taken from Shue's argument for the importance of basic liberty rights (Shue 1996, pp.80–81). A person who enjoys consistent health and wellbeing without a guarantee of health care services like basic essential medicines is like the citizen of a benevolent dictatorship who enjoys access to sufficient food and protection from harm – in both cases the ‘lucky citizen’ does not enjoy anything by right, but merely through good fortune in avoiding disease or the violence of a dictator (Shue 1996, pp.74–75). In both cases the ‘lucky citizen’ may enjoy a decent standard of living for their entire life, but

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[1] I set out the kinds of interventions to which right holders are entitled in the following chapters, and discuss the way in which limits on entitlement may be defined.

they do so in extremely precarious circumstances, and with no guarantee that this situation will continue. Both these citizens enjoy their welfare status only because of the contingencies of forces beyond their control. In both cases, factors beyond their control, such as the behaviour of a dictator, or the spread of infectious disease or occurrence of accidental injury, can reduce their welfare, and make it impossible to enjoy any other rights. As such, since both agents are completely unprotected against deprivations which could make enjoyment of any rights impossible, they cannot be said to have any rights at all (Shue 1996, p.33). Consequently, to have a right to anything requires that right holders enjoy rights to at least basic essential medicines, since this access is vital in order for them to be protected from those threats to health with the potential to inflict rights-inhibiting harms.

Having claimed that the basic right to health care entitles right holders to basic essential medicines, it is necessary to provide at least the outline of a definition of which medicines qualify as basic and essential. While I shall not attempt to explore this definition in depth, a solution can be derived from Shue’s definition of standard threats, as discussed in chapter one. Standard threats, according to Shue are those ‘common, or ordinary, and serious but remediable threats’ to individual welfare (1996, p.32). In the context of disease and medical treatment, standard threats are those conditions which impose severe deprivations, are treatable, and are relatively common. Given the role of the basic rights in enabling the enjoyment of all other rights, an additional aspect of the definition of standard threats is that they impose barriers on the ability to enjoy other rights, a point I explore in more detail in chapter four. Correlatively, basic essential medicines are those drugs which provide protection or treatment against these serious, and 'predictable remediable threats' (1996, p.33).[1] This definition would thus include drugs for potentially fatal diseases such as tuberculosis, malaria, and diarrhoeal disease (Mathers et al. 2008, p.72), while excluding medicines for infertility for example.[2]

So far in this section I have argued that the basic right to health care entitles right holders to at least basic essential medicines, and that denial of these entitlements imposes significant harms. Further, I have suggested that basic essential medicines are those which respond to standard threats to health. In the rest of this section I argue that the TRIPS regime imposes barriers to access which prevent many right holders from enjoying access to even basic essential medicines.

As noted in the previous section, the TRIPS regime provides pharmaceutical innovators with monopoly privileges which enable them to maximize profits before their monopoly expires (Chitsulo et al. 2000, p.49; Barton 2004, pp.146, 148; Bortolotti 2006, p.172; Daniels & Sabin 2008, p.107; Battin et al. 2009, p.262; Bannerjee et al. 2010, p.167). The protections offered by the TRIPS regime have two significant consequences;[3] firstly, monopoly protected prices are typically extremely high and often prevent poor right

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[1] In chapter four I suggest a framework for analysing deprivation scenarios in which aid might be owed and for prioritising the allocation of medical resources.

[2] See also (World Health Organization 2013).

[3] I discuss these consequences in more detail later in the chapter.

holders from being able to access them (Viravaidya et al. 1996, p.11; Flint & Payne 2013, pp.500–501). This is harmful to poor right holders because, as noted above, lack of access to needed drugs can create severe, long term deprivations in welfare and the ability to enjoy other rights, and restrict the ability to recover from those deprivations.[1]

Secondly, the provisions of the TRIPS regime encourage researchers to pursue the development of medicines which will generate the most return on investment (Hubbard & Love 2004, p.148). This has the consequence of encouraging pharmaceutical researchers to neglect research into medicines for diseases which primarily affect poor people since they are likely to be less profitable (Barton 2004, p.148; Bannerjee et al. 2010, p.167).[2] As such, not only does the TRIPS regime prevent poor people from accessing basic essential medicines in the short term, it also makes it less likely that medicines which are responsive to their needs will be developed in the long term. This problem is exacerbated by the fact that poverty and disease have an almost reciprocal relationship - poverty increases vulnerability to disease (Buchman 2012), which makes it harder to escape poverty, which in turn increases the risk of deprivations of health in the long term (Dasgupta 1993, pp.12, 405; Price-Smith 2002, pp.84, 98).[3] Consequently, by disincentivising the development of medicines for poor people in the short term, the TRIPS

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[1] William Ryan has noted for example that ‘health costs money’ (1971, p.170).

[2] I discuss the problem of the ‘10/90 gap’ in pharmaceutical research in more detail below (Ramsay 2001; Vidyasagar 2005).

[3] In chapter five I argue that the role of accessible health care services in promoting economic growth provides one self-interested reason to ensure basic health care services to all persons.

regime contributes to their impoverishment and thus increases their vulnerability to deprivations of health in the short, medium, and long term.

My goal in this section has been to argue for the importance of basic essential medicines for the enjoyment of any rights, and to argue that the TRIPS regime prevents many right holders accessing basic essential medicines. However, the TRIPS regime is intended to function to the benefit of both producers and consumers of pharmaceutical products (Kabiraj 1994, p.2996). As such, the inaccessibility of basic essential medicines caused by the TRIPS regime may be claimed to be a necessary by-product of protecting intellectual property rights, and encouraging innovation. In the following sections I argue that neither of these justifications for the deprivations caused by TRIPS are successful. As such, I argue that the TRIPS regime represents failures on the part of its advocates, authors, and beneficiaries to fulfil their duties to avoid depriving. I start by considering the deontological defences of the TRIPS regime, before moving on to consider consequentialist defences in section six

2.4 – Rejecting Deontological Defences of TRIPS

In the previous section I argued that access to basic essential medicines is entailed by the basic right to health care, and that the provisions of the TRIPS regime prevent many from enjoying such access. Although denial of access to essential medicines is extremely harmful, it may be defended in two ways, the first of which I examine and reject in this section. The first potential defence of the TRIPS regime is derived from the asserted importance of the intellectual property rights of pharmaceutical innovators (Kabiraj 1994, pp.2991–2992; Oddi 1996, p.424).[1]

There are two variations of this claim; the first is a Nozickian argument, critiqued by Thomas Pogge (2008c, pp.228–229), that discoverers of novel pharmaceutical products are entitled to complete control over the substances they discover or invent because they do not make anyone worse off by restricting access to their discoveries. That is, it is argued that the absence of harms caused by such restrictions justifies the provision of very strong intellectual property rights over all tokens of pharmaceutical types (Nozick 1974, pp.181–182). As noted by John H. Barton (2004, p.147), this claim is evidenced by article 27 of the original TRIPS regime which specifically protects both ‘products and processes, in all fields of technology’ (World Trade Organization 1994, article 27), and therefore enables patent holders to control all tokens of a given pharmaceutical type. The second variation of the argument from the importance of intellectual property rights is that such rights are also a type of basic subsistence right, and that to deny them would be to undermine the ability of innovators to enjoy any other rights. I examine and reject these claims in turn below.

2.4a – Novel Products, Patents, and the Type/Token Distinction

In this section I examine and reject the first deontological defence of strong intellectual rights protections which might excuse the deprivations caused by

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[1] As noted by Hettinger (1989, pp.36–37), this is an obviously Lockean claim about the role of labour in assigning ownership of property rights (Locke 1980, chap.5).

the TRIPS regime, Robert Nozick's claim that innovators do not violate the Lockean proviso to leave 'as much...and as good' for others (Locke 1980, sec.33–34) when they assert rights to control all tokens of the pharmaceutical types they discover or invent (Nozick 1974, pp.180–181). Following this argument, it is claimed that the monopoly controls enabled by the TRIPS regime do not violate the duty to avoid depriving. Following Thomas Pogge, I reject this claim on the grounds that Nozick's argument cannot justify the monopoly rights granted by TRIPS (2008c, pp.228–229). In addition, I argue that such monopoly rights do actually deprive right holders of important health care goods.

To make this argument I first outline Nozick's claim that the discoverers of novel pharmaceutical substances are entitled to monopoly control over those substances. Second, I outline two responses to the Nozickian defence of the TRIPS regime, proposed by Thomas Pogge, and Sridhar Venkatapuram. In doing so, I argue that the TRIPS regime deprives right holders of a research infrastructure to which I argue they are entitled under the basic right to health care, and so does deprive right holders of goods to which they are entitled. Finally, I argue that the Nozickian argument fails to provide a convincing defence of the deprivations caused by TRIPS, but note that an alternative defence based on rights is possible.

First, Robert Nozick has argued, via the Lockean argument of the origin of property rights (Locke 1980, chap.5), that those who discover 'new substances' (including new medicines) are entitled to time-limited patents which grant them monopoly powers over all tokens of a discovered type (1974, p.182). This is because, according to Nozick, those who discover ‘new substance[s] in an out-of-the-way place’ are entitled to ‘appropriate’ the entire supply of that substance (1974, p.181). Having done so, they do not make anyone worse off than they would have been without the invention or discovery of the substance when they impose financial restrictions on access to it. As such, they are entitled to restrict or allow access to their discovery or invention however they see fit (Nozick 1974, p.181).[1] Nozick argues that inventors and discoverers adhere to the Lockean proviso to leave ‘as much...and as good’ for others even when they restrict access to the substance (Locke 1980, sec.33–34). Notably, Nozick argues that other persons are free to synthesize the same substance from available resources if they are able to do so and as long as they can prove the independence of their discovery (1974, p.182). That is, Nozick asserts the right to monopoly control over pharmaceutical types unless independent discovery is proven by the ‘secondary discoverer’.[2] I discuss two criticisms of the Nozickian defence of the TRIPS regime below.

The first criticism of the Nozickian defence of monopoly controls over novel pharmaceutical types is proposed by Pogge who argues that Nozick’s argument for the non-harmfulness of monopoly control of novel products does not explain how a patent holder can ‘acquire veto powers over what others

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[1] Nozick also argues that when a ‘medical researcher who synthesizes a new substance that effectively treats a certain disease and who refuses to sell except on his terms does not worsen the situation of others by depriving them of whatever he has appropriated’ (1974, p.181).

[2] Though he also claims that independent discovery is unlikely (1974, p.182).

can do with stuff they legitimately own' (2008c, p.228). That is, merely because restricting access to the products of one's work does not make anyone worse off is not an argument sufficient to entitle the innovator to prohibit other persons from taking similar action with their own property. It may not harm others if the discoverer or inventor of a novel type refuses to sell tokens of it to them, but this does not justify giving control over the entire type to that innovator. The conclusion does not follow from the argument according to Pogge.

Pogge elaborates on this point by arguing that the monopolistic control of types proposed by Nozick actually violates the Lockean proviso on which Nozick bases his argument. This is because, Pogge argues, those asserting monopolistic control over types do in fact make 'others worse off by depriving them of the opportunity to invent the medicine without having to prove that they did so independently. And he is creating scarcity by claiming that only he can grant others access to certain uses of their property' (2008c, p.229).[1] That is, by granting monopoly powers over chemical types, rather than the specific tokens of that type created by an innovator, Nozickian monopolies deplete the opportunities open to other innovators for discovery, invention, and the private use of their own property.[2] Such restrictions, Pogge claims, 'violate the Lockean proviso by not leaving enough and as good for others' (2008c, p.229). As such, Pogge argues that the Nozickian argument

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[1] Edwin C. Hettinger also makes a similar claim in a more general discussion of the problems associated with patent law (1989, p.44).

[2] For additional examination of the token/type problem for the TRIPS regime see (Biron 2010).

for the right to control one’s own property actually contradicts Nozick’s argument for monopoly control over types. This is because such controls violate individual rights to control one’s own property (2008c, p.229).

By imposing restrictions on what right holders may do with their property Nozickian monopolies allow patent holders to restrict access not only to the tokens of the type which they personally produce, but to all tokens of the type. Consequently, the Nozickian patents guaranteed by the TRIPS regime deplete the range of medically effective chemical products available for public use by prohibiting the manufacture of generic medicines by the legitimate owners of the necessary chemical compounds. As such, in granting control over types to those who first discover a token of that type, the TRIPS regime encourages behaviours which fail to meet the demands of the duty to avoid depriving by allowing pharmaceutical companies to render access to essential medical products impossible for many people. Such actions thereby deprive right holders of both accessible medicines, and a system which is capable of producing generic versions of novel drugs at low prices, as I discuss below.

The second response to the Nozickian defence of the TRIPS regime is derived from Shue’s claim that having a right to anything also implies rights to the things which are absolutely necessary for the enjoyment of the first right (1996, p.31), and from the importance of access to basic essential medicines for enjoyment of any rights.[1] Therefore, if it is accepted that basic essential medicines are vital components of the basic right to health care, it follows that systems must exist which enable or at the very least allow the production and distribution of such drugs.[2] Sridhar Venkatapuram has articulated this idea as a right to have ‘social institutions pursue policies that will help them [right holders] realize their CH [capability for health]’ (2011, pp.159–160).

Following this claim it can be argued that the basic right to health care entails the existence of research programmes which emphasise the development of medicines for diseases which primarily affect the poor. However, as I discuss in section 2.5, the TRIPS regime fails to promote such research. As such, it can be argued that the TRIPS regime deprives many of a system of pharmaceutical research to which, I argue, they are entitled because of their basic rights to health care. In addition, the increased protections of intellectual property rights provided by the TRIPS regime has also reduced the capability of the generic medicines industry to produce generic medicines which would benefit those unable to afford patented drugs (Helpman 1992, p.1248). Indeed, as noted above, Pogge has argued that the TRIPS regime makes such systems impossible (2008c, p.229). As such, the TRIPS regime can be said to deprive vulnerable persons of the existence of an industry with the ability to develop generic medicines, thereby also depriving them of

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[1] I argued for this point in the previous section.

[2] I argued for entitlements to basic essential medicines earlier in this chapter, and elaborate on this argument in the following chapters.

access to basic essential medicines (Helpman 1992, p.1248; Schulz 2004, p.101; Lea 2008, p.57; Adusei 2013, p.261).

In this section I have argued that the Nozickian 'non-harmfulness' argument cannot justify the restrictions imposed by the TRIPS regime on the accessibility of basic essential medicines (Nozick 1974, pp.181–182; Pogge 2008c, p.229). Further, I have argued that not only are the restrictions on accessibility unjustifiable on these grounds, the TRIPS regime also unjustifiably deprives right holders of systems of research and development which are vital to the fulfilment of the basic right to health care. In the following section I examine the second possible deontological justification for the TRIPS regime – the claim that intellectual property rights must be prioritised over the basic right to health care.

2.4b – Prioritising Important Rights: Intellectual Property Vs. Health Care

In this section I examine and reject the second deontological defence of the monopoly protections provided by the TRIPS regime; that intellectual property rights are a vital part of the basic right to subsistence and that as such, must be treated with at least as much, if not greater priority than the basic right to health care.[1] If this argument is accepted, the deprivations caused by the TRIPS regime are an unfortunate, but justified consequence of adequately protecting basic intellectual property rights. I reject this claim by arguing that even if intellectual property rights are basic in the sense

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[1] This objection was suggested to me by Dr. Laura Biron, to whom I am very grateful, in conversation about the possible ethical arguments for the TRIPS regime.

described by Shue, this does not justify prioritising them absolutely over all other rights. To make this argument I first explain the defence of the deprivations caused by the TRIPS regime. Second, I provide data about the costs and risks associated with pharmaceutical research. Third, I reject the absolute prioritisation of intellectual property rights by arguing that the monopoly protections provided by the TRIPS regime are incompatible with the basic rights model, and with the long term enjoyment of intellectual property rights, *even if* such rights are treated as basic rights.

First, the deontological defence of the monopoly protections provided to pharmaceutical innovators by the TRIPS regime I discuss in this section is that intellectual property rights are a kind of basic subsistence right. This is because the development of ideas, of which pharmaceutical innovation is one example, is a justifiable means of achieving personal subsistence. Therefore, intellectual property rights guarantee innovators that they will not be deprived of the products of their work, with which they support themselves (Oddi 1996, p.424; J. H. Reichman 1996, pp.12–13). Put differently, intellectual property rights provide the social guarantees necessary for innovators to achieve subsistence. If it is correct that intellectual property rights are included within the basic right to subsistence then, by the logic of the basic rights model, they are necessary for the enjoyment of all other rights. As such, it might be argued that to deny intellectual property rights is to deny all other rights held by innovators.[1]

Second, this claim to the basic necessity of subsistence rights is supported by three empirical points about the implications of pharmaceutical research as a means of subsistence. First, the cost of researching and developing new medicines for market is extremely high, estimated at between US$500 million and US$2,000 million, depending on the drug researched (Adams & Brantner 2006, p.420). Second, the risk associated with pharmaceutical research is also claimed to be very high, meaning that pharmaceutical companies can expend significant resources yet may receive limited return on investment (Kabiraj 1994, p.2991). Third, competition with generic medicines can significantly reduce the profitability of a given pharmaceutical product, particularly given the high costs of research and development. For example, a study found that one year after generic medicines were available for substitution for original products, manufacturers in Finland suffered an 11.5% (range 1.5%-40%) reduction in turnover (Timonen et al. 2009, p.118). Correlatively, an earlier, multi-industry, study of U.S. companies found that American companies lost US$2.1 billion of profit, equivalent to 1.8% of total sales, as a result of international patent infringement prior to the TRIPS regime (Feinberg & Rousslang 1990, pp.86–88; Helpman 1992, p.1248).

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[1] I outlined the necessity criterion of the basic rights in the previous chapter (Shue 1996, p.19).

These data suggest that pharmaceutical innovators require strong patent protections in order to ensure their survival in a risky, expensive, and competitive market.[1] In the absence of such protections for the pharmaceutical industry it is argued that pharmaceutical research would be insufficiently profitable to justify their continued research – in effect, in the absence of strong patent protections, it is claimed that pharmaceutical research would be unsustainable (Kabiraj 1994, p.2991; J. H. Reichman 1996; Barton 2004, pp.146–147). If intellectual property rights are accepted as a kind of basic subsistence right then it may be argued that the deprivations the regime causes are justifiable on the grounds that they are an unavoidable consequence of adequately protecting an important aspect of the basic right to subsistence.[2] However, as argued above, basic essential medicines are also a vital component for the enjoyment of a basic right, and thus of all other rights.[3] As such, enjoyment of each right, to essential medicines and to intellectual property, is necessary for enjoyment of the other, and of any other rights. As I argue below, this means that the absolute intellectual property protections guaranteed by the TRIPS regime are incompatible with the basic rights model. Equally, if the status of intellectual property as the substance of a basic right is accepted this also means that some way of

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[1] It has been suggested that the rewards to which one is entitled is proportional to the amount of work and risk voluntarily undertaken by innovators (Hettinger 1989, pp.41–42). Given the risks, cost and effort of pharmaceutical research, such a position would justify very large rewards for innovators.

[2] Further, because of the interrelated nature of the basic rights, protecting basic intellectual property rights is necessary to protect the basic right to health care.

[3] Therefore, since the rights to basic essential medicines and to intellectual property are each constituent elements of basic rights, denial of either right appears to restrict the ability to enjoy *any* other rights.

guaranteeing intellectual property rights which is compatible with the basic right to basic essential medicines must also be found.

Third, the guarantees provided by the TRIPS regime to pharmaceutical innovators mean that for many, access to basic essential medicines is impossible. Further, the extent of these guarantees also means that intellectual property rights will always be prioritised ahead of rights to basic essential medicines. Therefore, no right to basic essential medicines is possible under the monopoly protections offered by TRIPS, because access to basic essential medicines is contingent upon being able to afford to purchase them. However, as argued above, access to basic essential medicines is a component of the basic right to health care, the fulfilment of which, as a basic right, is necessary for the enjoyment of all other rights, including other basic rights.[1] Therefore, to deny the right to basic essential medicines by asserting absolute monopoly controls over intellectual property rights is to deny part of the basic right to health care, and to thus remove one of the necessary conditions of the right to intellectual property, and thus to 'cut…the ground from beneath itself' (Shue 1996, p.19).[2]

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[1] For example, if one has no right to treatment for malaria, one has no guarantee that incapacity will not prevent being able to enjoy the benefits associated with control of one's intellectual property. Malaria is highly correlated with poverty, with which it has a reciprocal relationship, and has a strong negative impact on economic development (Sachs & Malaney 2002, p.681). As such, the disease is entirely capable of imposing significant restrictions on the ability of right holders to enjoy any rights.

[2] While holders of pharmaceutical patents are perhaps unlikely to suffer deprivations of health facilitated by the inaccessibility of basic essential medicines, this is because of their considerable wealth and power, rather than guarantees provided by a right. Following the arguments presented in the previous chapter, enjoyment of intellectual property rights *qua* rights requires a guarantee that *in extremis* basic essential medicines will be made available, something which the TRIPS regime currently makes impossible.

Consequently, even if intellectual property rights are accepted as basic rights, they cannot entail the kinds of protections guaranteed by the TRIPS regime (Pogge 2008c, pp.228–229; Lea 2008, p.50). Similarly, prioritising the right to health care in the same absolute manner may also undermine the ability to guarantee it, since doing so may undermine other important basic rights. When two basic rights are in conflict it is therefore necessary to acknowledge the importance of compromise between the two. For example, limiting the basic rights to freedom of movement of persons infected with extremely drug resistant tuberculosis may be legitimate when failure to do so will expose others to great risk of harm (Battin et al. 2009, pp.148–149).

In order to adequately guarantee the right to intellectual property, even if it is taken to be a basic right, it is necessary to weaken the guarantees that it provides to innovators in order to avoid making the enjoyment of other basic rights, and thus itself, impossible.[1] For example, rather than providing absolute guarantees of entitlements to complete control over sale price or the choice of markets, it may be appropriate to strengthen legal provisions which mandate more accessible pricing strategies or to guarantee access to basic essential medicines for all persons while adequately compensating innovators for the use of their intellectual property (Hubbard & Love 2004; Sonderholm 2009; Pogge 2010).[2] Such compromises are compatible with the basic rights

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[1] It may seem counterintuitive that in order to adequately guarantee the right to intellectual property it is necessary to weaken the guarantees it provides to right holders, but doing so is necessary because of the importance of access to basic essential medicines for the enjoyment of all other rights.

[2] As I discuss later in this chapter, various models have been suggested as a means to achieve this goal (Sonderholm 2010b). While the approaches I mention are utopian, they

model in general, and there are parallels to be seen in other possible conflicts between the basic rights. For example, as Shue argues, the basic right to freedom of movement does not extend so far as to intrude upon the security, subsistence or liberty rights of other persons (1996, pp.78–81). Shue also explicitly acknowledges the legitimacy of restricting liberty in contexts where right holders are a threat to others (1996, p.79).

Placing limits on the powers granted to pharmaceutical innovators is reasonable, and compatible with the basic rights model, and with the importance of intellectual property rights for two reasons; first, in the absence of compromises on intellectual property rights in the context of pharmaceutical development, many people will have their basic rights to health care denied, with potentially fatal consequences. Second, and resulting from this first point, to deny the basic right to health care, which includes a right to basic essential medicines, is to deny all other rights given the necessity criterion discussed in the previous chapter (Shue 1996, p.19). Therefore, even if rights to intellectual property are basic rights (as constituent elements of the basic right to subsistence) they cannot be used to deny the basic right to health care, because doing so would remove one of the necessary conditions for enjoyment of the right to intellectual property itself.[1] As such, adequately guaranteeing intellectual property rights demands that rights to basic essential medicines, as part of the basic right to health care,

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are considered merely as a means to demonstrate that alternative ways of thinking about intellectual property rights are possible, and that the TRIPS regime is not an inevitable or immutable aspect of pharmaceutical development.

[1] Doing so would thus fail the universalisability condition of the categorical imperative (Kant 1998, p.AK 4: 421).

are also guaranteed. As noted above, this is likely to require that intellectual property rights must not confer absolute monopoly rights upon innovators because doing so leads to denials of basic health care rights.

In this section I have argued that even if intellectual property rights qualify as basic rights, this does not justify the monopoly patent protections currently provided by TRIPS. This is because such protections are incompatible with the enjoyment of other basic rights, and thus with the enjoyment of intellectual property rights. Therefore, the extent of the guarantees provided by TRIPS must be reduced in order to allow better protection of basic health care rights, and by extension intellectual property rights.

It may seem counterintuitive to suggest that protecting intellectual property rights requires us to reduce the legal provisions which currently protect them. However, while the strength of the legal protections provided by TRIPS must be acknowledged, they guarantee far less in real terms when the basic right to health care is not also guaranteed. While a person may have a *legal* right to control of their intellectual property, as noted above, if they have no basic right to access basic essential medicines in the case of severe deprivations of health, they are unlikely to be able to actually *enjoy* their intellectual property rights; as Shue has noted, there is an important difference between ‘merely having a right and actually enjoying a right’ (1996, p.20).

In the following section I summarise my rejection of the deontological defences of the TRIP regime, and acknowledge that even if such claims fail, the TRIPS regime may still be in the best interests of most people because of the realities of pharmaceutical development, and the needs of global public health.

2.4c – TRIPS and Rights

In the previous sections I have made four claims; first, that the TRIPS regime deprives right holders of accessible goods, basic essential medicines, to which they are entitled. Second, that it also deprives right holders of a system of pharmaceutical research necessary to produce affordable basic essential medicines. Third, that the TRIPS regime is not justifiable on either Lockean or Nozickian grounds. Finally, that even if intellectual property rights qualify as basic rights, this does not justify the kinds of absolute monopolistic patent protections that the regime provides.

However, it may be possible to excuse the deprivations caused by TRIPS and justify the limitations on important rights that it imposes on consequentialist grounds if the regime effectively incentivises the development of new medicines and delivers those medicines to the widest possible audience. That is, since innovation in pharmaceutical research is something which all persons have reason to value, if TRIPS generates outcomes which are on balance superior to other approaches, even accounting for deprivations of rights (i.e. if it preserves basic rights more effectively than alternatives), then the restrictions on accessibility it causes may be justifiable. However, as I argue in the following section TRIPS does not appear to achieve the outcomes with which the deprivations it causes might be excused.

2.5 – Consequences of TRIPS: Challenging Consequentialist Justifications

In this section I discuss and reject consequentialist defences for the deprivations caused by the TRIPS regime. To do so I first set out the main consequentialist defence of TRIPS, that it is necessary to promote pharmaceutical innovation which all persons have reason to value. Second, I argue that the TRIPS regime does not promote innovation effectively with reference to two key issues. Third, I argue that the TRIPS regime does not generate the kinds of innovation on the scale needed to justify the deprivations that the regime causes.

First, the consequentialist justification for the monopoly protections offered by the TRIPS regime is based on the importance of the development of new medicines for global public health and individual welfare (Lowrance 2012, p.1).[1] While access to basic essential medicines is not the only thing that is required by the basic right to health care, guaranteeing all people access to certain basic essential medicines would contribute significantly to alleviating much of the suffering and premature mortality that affects millions of people around the world (Pogge 2008b, pp.1–2). As such, it is important that effective medicines continue to be produced in order to meet global health care needs (Lowrance 2012, p.1). Further, given the risk and expense of the production of medicines,[2] patents have been argued to be necessary in order

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[1] As argued above, access to at least basic essential medicine is an essential component of the basic right to health care.

[2] As noted above, one estimate of research and development costs for a single new medicine ranging from between US$500 million to $2,000 million (Adams & Brantner

to ensure the continued production of medicines which all persons have reason to value (Kabiraj 1994, pp.2991–2992).

There are two aspects to the consequentialist justification for the TRIPS regime; firstly, it can be argued that the monopoly protections offered by the TRIPS regime are necessary to ameliorate the inherent financial risks of pharmaceutical research and thus to render investment in innovative research financially attractive (Pogge 2008c, p.237; Sonderholm 2010a, p.1108; Sonderholm 2010b, p.3). Without such incentives it is argued drug companies would be unwilling to take the financial risks needed to pursue innovative research (J. H. Reichman 1996, pp.12–13). As such, time-limited, global monopolies must be granted to the producers of novel pharmaceutical products in order to enable them to recoup the vast costs of drug development, compensate them for the risks which they undertake, and incentivise innovation.

Secondly, it is argued that alternative systems of protecting intellectual property rights which were in place prior to the TRIPS regime fail to adequately promote innovation in pharmaceutical products, contributing to significant risk long term. Prior to the advent of the TRIPS regime, alternative strategies for pharmaceutical innovation were in place in various parts of the world, most notably in India and Brazil (Adelman & Baldia 1996; Schulz 2004). Such systems recognised intellectual property rights, but to

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2006, p.420). I also noted the significant risk and competitiveness of the pharmaceutical industry in the previous sections.

methods of production, rather than pharmaceutical products themselves (Adelman & Baldia 1996, p.520; Barton 2004, p.147). As such, it may be argued that such systems did not encourage the innovation necessary to ensure the development of new essential medicines. Given the accelerating evolution of drug resistant strains of disease (Pogge 2008c, p.232; Wilson 2012), the range of medicines which can be used to treat potentially lethal diseases is shrinking, presenting an enormous concern for global public health (Cohen 1992; Kunin 1993; Weinstein 2001; Cars et al. 2008).[1] As such, it may be argued that while many drugs which are currently under patent would offer large health benefits to those who cannot afford them, a long term research strategy which only focused on improving efficiency in duplicating existing medicines is not only unsustainable, but actively dangerous or negligent. Put differently, it might be argued that improving accessibility now would fatally undermine innovation, and consequently accessibility, in the future.

If these arguments are accurate, it seems there is good reason to endorse TRIPS, since it enables the development and provision of goods which there is very good reason to value (and which are required by the basic right to health care). According to this argument, TRIPS is the best option available for developing new medicines despite the deprivations it causes. Consequently, it might be claimed that TRIPS, or something like it, is

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[1] Though it can also be argued that the high cost of drugs, which is encouraged by the TRIPS regime, has also contributed significantly to the evolution of drug resistance, since patients may have limited access to effective medicines and thus take incomplete or inappropriate courses of medication which do not cure disease, but do encourage antimicrobial evolution (Farmer 1999, pp.198–199; Battin et al. 2009, p.239).

required by the basic right to health care, despite its role in blocking access to essential medicines, because the regime enables to the greatest extent possible the development of medicines needed to prevent the significant deprivations caused by deprivations of health. However, there are two wide-reaching and harmful consequences of the TRIPS regime which significantly weaken the consequentialist justifications offered in its defence.

Firstly, it is far from clear that the TRIPS regime does promote the development of medicines for diseases which account for a large proportion of the ‘global burden of disease’ (GBD) (Pogge 2008c, p.225; World Health Organization 2014a). The ongoing ‘10/90 gap’ phenomenon mentioned above (Ramsay 2001, p.1348; Vidyasagar 2005, p.55; Selgelid 2009, p.434), demonstrates that while TRIPS may encourage innovation in medical research it is not necessarily innovation which benefits many people, a point which undermines the argument from the importance of innovation.

This point is rendered in even starker terms when it is noted that of the 1,035 new drugs approved for use in the United States by the American Food and Drug Administration (FDA) between 1989 and 2000, 76% conferred no additional benefit over existing medicines, while only 23% offered any significant benefit over existing drugs, and less than 1% were designed for ‘neglected diseases’ or those that ‘primarily affect the poor’ (Hubbard & Love 2004, p.0148).[1] That is, not only are diseases which affect the majority

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[1] In addition, in the five years following 1999, of the 163 new medicines approved by the FDA, only ‘five were for tropical diseases and none for tuberculosis. Tropical diseases ad

of people ignored in favour of more profitable afflictions, when new medicines are developed the vast majority of them offer no significant benefit over existing medicines.[1] Therefore, it seems that the claim that TRIPS promotes innovation in the development of novel medicines to the benefit of everybody, or even a majority, exaggerates the success that TRIPS has in achieving this goal.[2] The claim also ignores the tendency of pharmaceutical companies to seek to maximise profit through researching so called ‘me too’ drugs, and capitalising on existing market opportunities rather than develop new pharmaceutical responses to neglected threats (Hubbard & Love 2004, p.0148).

Ignoring for the moment the enormous disparity in the allocation of research funds demonstrated by these studies, the fact that less than one-quarter of all the drugs approved by the FDA in the period studied by Hubbard and Love had any benefit over existing medicines is notable. The preference for drugs which seek to claim a share of an established pharmaceutical market, over innovative medicines for previously ignored conditions or improvements in existing medicines, seems to contradict the claim that monopoly protections offered by patent law globalized by TRIPS serve to promote innovation. When considering the scarcity of research into drugs for diseases which

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tuberculosis together account for 12 percent of the total disease burden’ (Pogge 2008c, p.237).

[1] It must be acknowledged that part of the period covered by the Hubbard and Love survey just mentioned, precedes the advent of TRIPS, and so it may appear that application of new rules may have changed things for the better. However, the survey focused on the United States of America, the patent laws of which can fairly be said to have formed the basis or foundation of the TRIPS regime. As such, while the time period includes several ‘pre-TRIPS’ years, the laws which were in operation prior to TRIPS were similar.

[2] This point also applies to domestic patent law.

mainly affect poor people this issue jumps into even starker contrast. While those fortunate enough to fall outside of the poverty category do not seem to enjoy significant benefits in terms of innovation, the poor are left worse off still, due to the unequal distribution of spending and research. As such, it appears that the innovation used to justify the limited accessibility of new medicines is far less prevalent than may be assumed given the weight assigned to the argument.

The second argument against the consequentialist defence of the TRIPS regime, put by Thomas Pogge (amongst others), is that the TRIPS regime rewards the ability to sell, rather than impact on the global burden of disease (Hollis & Pogge 2008, p.77; Bannerjee et al. 2010, p.167). As such, the monopoly period granted by TRIPS is generally used to maximise profits through high prices, and the over-selling of new medicines (Pogge 2008b, p.10; Bannerjee et al. 2010, p.167). It is this which is the main cause of the inaccessibility of novel medicines, and which inevitably excludes many people from being able to access needed medicines on grounds of cost (Barton 2004, p.148). Further, since new medicines will often only enjoy a relatively brief period of maximum profitability whilst under patent, pharmaceutical manufacturers may lack incentive to continue production of expensive medicines once patents lapse. For example, production of the drug cefixime, an orally administered medicine used to treat venereal disease, ceased once its patent expired since it was no longer profitable (Battin et al. 2009, p.35).

In addition, due to the evolution of antimicrobial resistance, the period in which pharmaceutical products are under patent is often the time during which they are most effective against disease, meaning that those unable to afford patented medicines lose out on accessing medicines when they are most effective, and may potentially only be able to afford them once they are no longer effective (Pogge 2008c, p.232). As such, while the evolution of antimicrobial resistance does provide incentive to develop new medicines, it also speaks against the imposition of monopolistic patent protections, because they exclude poor persons from having access to any but the least effective medicines, and thus expose them to even more severe risk of harm.

Despite significant ‘valuable and unique’ advantages that the drug offered over its competitors, production of it (by a competing manufacturer) did not resume for six years because, due to high production costs, it was not deemed sufficiently profitable (Battin et al. 2009, p.35). As such, it appears that TRIPS disproportionately encourages the development of drugs which are predicted to be profitable, rather than medicines that will generate overall benefit to the global populace. Therefore, it seems there is good reason to distrust the claim that TRIPS, or other monopoly granting systems, promotes the kind of innovation and accessibility which would serve the health care interests and needs of the majority of right holders.

In this section I have suggested that consequentialist appeals to the importance of pharmaceutical innovation ignore the extremely significant limitations of the innovation actually promoted by the TRIPS regime. I have also argued that the deprivations inflicted on vulnerable persons far outweigh the benefits generated by the TRIPS regime. Therefore, the deprivation caused by the TRIPS regime cannot be justified with reference to the benefits the regime generates. As such, the authors of the regime fail to fulfill the impartiality condition of the duty to avoid depriving because in seeking to maximise benefits for a minority, they have failed to adequately recognise the deprivations TRIPS will inevitably cause to vulnerable persons. In doing so, they fail to abide by the demands of the impartiality condition of the duty to avoid depriving. In the following section I set out in more detail the way in which the TRIPS regime does not merely fail to provide the best outcomes in terms of pharmaceutical innovation, but actively deprives people of the substances of their right to health care.

2.6 – Partial Behaviour and TRIPS: How TRIPS Violates the Duty to Avoid Depriving

So far in this chapter I have made three claims; first, that the basic right to health care guarantees right holders access to basic health care medicines. Second, that the TRIPS regime deprives right holders of such medicines. Third, that the mechanisms by which these deprivations are caused cannot be justified on either deontological or consequentialist grounds. Consequently, I make a fourth claim, that the TRIPS regime represents a failure on the part of numerous agents to fulfill their duties to avoid depriving. In this section I set out how the authors and supporters of the TRIPS regime fail to abide by the impartiality condition (as opposed to the non-malevolence or conscientiousness conditions), and thus fail to fulfill their duties to avoid depriving. To do so, I first reiterate the different types of behaviour which qualify as failures to fulfill the duty to avoid depriving. Secondly, I argue that the TRIPS regime represents failure on the part of numerous agents to fulfill the impartiality condition of the duty to avoid depriving.

At the beginning of this chapter I noted that fulfillment of the duty to avoid depriving requires duty bearers to fulfill three requirements; non-malevolence, conscientiousness, and impartiality. Of these three requirements, the TRIPS regime, along with many other international agreements, can at least be said to respect, or at least avoid violating, the non-malevolence criterion. Harmful as it is, it is implausible to suggest that the goal of the TRIPS regime is to cause harm to those who cannot afford needed medicines because of it, the harm is ‘merely’ a consequence of the monopoly pricing the regime allows.

It is also only in a limited sense that the TRIPS regime represents a failure on the part of legislators to abide by the conscientiousness condition. This is because those denied access to essential medicines are not excluded carelessly through administrative oversight or a one-off aberrant practice. That is, the deprivations caused by TRIPS are not the result of accidental or aberrant consequences of actions which, if performed correctly, would not cause harm. Instead, the exclusion of right holders, and the deprivation it causes, are the result of a deliberate feature of the TRIPS regime which is intended to ensure maximum profits for some by allowing patent holders the right to exclude ‘financially sub-optimal’ customers through partial pricing strategies. That is, the exclusion of the poor is not an accidental side effect of the TRIPS regime which could be resolved through better enforcement of the regime; it is an integral part of a strategy to maximize profits for the pharmaceutical industry (Pogge 2008b; Pogge 2008c, pp.p.228–230). As such, the TRIPS regime represents a failure on the part of legislators to consider the interests of all persons impartially. Further, the economic behaviours enabled by TRIPS also demonstrate failures on the part of pharmaceutical companies to acknowledge the rights and needs of excluded groups.

The TRIPS regime cannot be classed as negligent because the regime is a piece of complex, international legislation, and the deprivations that it causes are not the result of isolated, or accidental incidents of careless behaviour. Rather, they are the result of a deliberate policy to prioritise the financial interests of innovators to the exclusion of all other considerations (Pogge 2008c, pp.228–229), including the essential health care needs of vulnerable persons. The behaviours enabled by the TRIPS regime are therefore not merely negligent because the deprivations they cause are an inevitable and predictable consequence of the deliberate actions of innovators, and as such have in a sense been chosen by the authors and beneficiaries of the TRIPS regime. Therefore, the TRIPS regime demonstrates that those involved in the creation, enactment, and maintenance of TRIPS, its authors and advocates, value the maximization of profit for patent holders through the absolute protection of intellectual property rights more than the basic rights of vulnerable persons. As such, the authors and advocates of the TRIPS regime are not negligent, but instead fail to be impartial between the rights and interests of different groups.

The TRIPS regime represents failure on the part of its authors to meet the demands of the duty to avoid depriving because the behaviour that it legitimises deliberately and actively deprives poor people of access to essential medicines, goods to which they are entitled under the basic right to health care. The TRIPS regime encourages this by allowing, and thus legitimising, exclusionary pricing strategies, exposing many to great risk of harm. Denial of access to essential medicines constitutes a failure to fulfill the demands of the basic right to health care because at least some basic medicines are essential for the prevention and treatment of numerous potentially lethal deprivations of health, as I discuss in more detail in the following chapter.

In this section I have argued that because the TRIPS regime enacts a global paradigm in which the intellectual property rights of a minority are prioritized excessively, its authors unjustifiably ignore the basic health care rights and needs of many people. As a result, TRIPS represents a failure on the part of legislators, lobbyists, and pharmaceutical companies (and their shareholders) to fulfill the impartiality requirement of the duty to avoid depriving. This failure is not merely because TRIPS is negligent towards the needs of vulnerable people, but because it deliberately and avoidably creates the circumstances in which they are deprived of goods to which they are entitled, and of which they are in desperate need, by undervaluing their basic rights and needs. In the following section I examine two additional examples of institutional failures to fulfil the duty to avoid depriving in order to illustrate the relevance of the duty to the goal of preserving a basic right to health care.

2.7 – Expanding the Argument – Two Additional Examples

In the previous sections I have argued that the TRIPS regime represents failure on the part of many agents to adhere to the demands of the duty to avoid depriving. In doing so, I examined deontological and consequentialist arguments to excuse the deprivations caused by TRIPS and to legitimise its actions. I argued that neither type of argument was successful in defending TRIPS, and that therefore the deprivations caused by the regime represent unjustifiable violations of the duty to avoid depriving. However, my goal was not merely to show the unjust nature of the TRIPS regime but to illustrate how global institutional structures, which are codified by law, can actively deprive right holders of the objects of their rights. In this section I provide two additional examples in order to demonstrate the applicability of my argument in a wider context.[1] To do so, I first outline the two examples, before explaining their relevance to my argument.

The TRIPS regime is not the only instance of a social institution which deprives right holders or encourages their deprivation in the context of health

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[1] I do not attempt to examine these examples in the depth in which I examined the TRIPS regime. Rather, my goal is merely to outline the way in which the same arguments apply.

care accessibility.[1] For example, Gillian Brock has noted the significant deprivations caused by wealthy countries recruiting medical professionals from poor countries, noting that in Zambia, of the 600 doctors trained since independence from colonial rule, only 50 remain in the country (2009, pp.198–204).[2] Similarly, I have elsewhere discussed in depth the accessibility problems created by commodifying health care services, which are largely caused by prohibitively high costs (West-Oram 2013).[3] In both of these cases significant deprivations are caused to right holders through supposedly legitimate institutional practice. Like the deprivations caused by the TRIPS regime, these deprivations are not the result of a deliberate desire to cause harm, or even negligence, but are rather the result of failure to adequately value the needs and rights of all persons equally.

In each of these examples, deprivation which is not the objective of the actions in question is caused to vulnerable persons. In addition, in each case, there is an argument to be made that current practice is legitimate because neither of the examples deliberately causes harm, and in the case of the recruitment of health care workers at least, important rights to freedom of movement are respected. For example, the goal of the emigrating doctor is not to deprive their exit nation of their expertise, but to improve their own circumstances, or avoid threats to their wellbeing. In addition, neither of the

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[1] Stewart also suggests a number of other structural violations of the duty to avoid depriving (2014, p.211).

[2] Paul Farmer has also discussed a similar issue in Haiti, noting that in the ten years following independence in 1957, 264 physicians were trained by the Haitian state medical school, all but three of which emigrated. Further, in the 1980s Haiti had 18 Medical Doctors per 100,000 people, while the USA had 250 and Cuba had 364 (1999, p.19).

[3] See also, (Schoen et al. 2011; Herman et al. 2011; Auerbach & Kellermann 2011).

examples given fails the non-malevolence condition. However, they both demonstrate legislative failures to fulfill the duty to avoid depriving through a combination of negligence and partiality.

In both of these examples the relevant duty bearers fail to account for the side effects of their actions, and in doing so cause, or allow to be caused, severe deprivation to large numbers of people. In the first example deprivation is caused by the governments of wealthy nations who actively recruit health care workers from poor countries since by doing so they deprive poor countries of important parts of a functional health care system (Taylor et al. 2011, p.2348).[1] Therefore, destination countries fail the impartiality condition by consistently recruiting medical professionals from poor countries and discounting, or neglecting entirely (Kingma 2006, p.53), the consequences for citizens of the exit nation. The second example similarly represents failure on the part of legislators to fulfill the impartiality requirement of the duty in virtually the same way as the TRIPS regime – it represents a deliberate decision to prioritise the maximization of profit over enabling access to basic health care services (Herman et al. 2011; Davis et al. 2014).[2] In this case, the rights of certain groups are treated as being of less importance than satisfying

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[1] It might also be suggested the departing medical professionals also deprive their exit nation of important medical assets unjustifiably in certain circumstances, since the cost of training medical professionals will have been at least partly met by the exit nation. As such, it might be suggested that medical professionals have obligations to provide health care to the nation which trained them, at least for a time. Of course, in cases where they are presented with an opportunity to flee a potentially hostile situation, they can hardly be blamed for doing so. However, we should recognise the consequences of their departure for their fellows, as we should acknowledge the high cost of medical training which must be absorbed by the exit nation.

[2] It should of course be noted that the recent Patient Protection and Affordable Care Act (PPACA) will make many major changes to the way that health care is delivered in the United States, though how successful these will be remains to be seen.

the financial demands of a preferred group in the same way as occurs for the TRIPS regime.

Such behaviour may not be actively malicious, since the goal is satisfying particular interests, or the prioritization of other, sometimes important rights, but nor is it entirely negligent, since in most cases the outcomes of specific policy decisions have been consistently demonstrated to deprive. For this reason the examples discussed in this chapter fail the impartiality condition of the duty to avoid depriving to at least some extent. By deliberately undervaluing the interests of excluded groups, and the importance of rights to basic health care services, these policies legitimize depriving behaviour, and thus create the circumstances in which deprivations occur. As such, they each legitimize and thus encourage the deprivation of vulnerable persons of the substances of their rights through treating the interests of those people as of reduced value, and establishing institutional structures which make their enjoyment of the basic rights virtually impossible.

As with the TRIPS regime, what is required in each of these cases is not better adherence to the guidelines of the relevant legislation, but a restructuring of the legislation governing these behaviours. More enforcement of the rules governing the sale of health care services, or the migration of health care workers will not lead to better fulfillment of the duty to avoid depriving, since in both cases existing ‘legitimate’ practice is what causes deprivation – the laws in each example are what are unjust, not the failure to adhere to them. In these examples, changes to the legislation which acknowledge the rights of those deprived by existing practice is therefore required in order to fulfill the demands of the duty to avoid depriving.

The additional examples mentioned here do not represent the full range of deprivation hazards which are relevant to the duty to avoid depriving in the health care context. Deprivations of health can be caused by the deliberate violence of malicious action; carelessness on the part of those engaged in risky but potentially legitimate endeavours, and, as with the examples mentioned here, the enactment of discriminatory and partial social institutions which undervalue the rights of non-preferred groups. The examples provided here are intended to highlight the impact that this last category of depriving behaviour can have on right holders.

2.8 – Alternative Approaches

In this section I offer a very brief overview of some alternative approaches to the problem of incentivising effective pharmaceutical research. I have not in this chapter attempted to provide an alternative model of incentivising pharmaceutical research since doing so would be a major project in its own right. Instead, my goal has merely been to set out what the demands of the duty to avoid depriving are in the context of the basic right to health care with reference to the particular example of the TRIPS regime. As such, exploring possible alternatives to TRIPS would not serve the wider goals of this thesis, which is to establish the general requirements of the basic right to health care, and show how they are compatible with Shue’s basic rights model. However, it is worth noting at least that a range of alternatives to the

TRIPS regime have been proposed, and while all are utopian, and unlikely to be adopted at any time in the near future, they each attempt to resolve the problems of inaccessibility and limited innovation generated by the TRIPS regime. In addition, each model acknowledges the importance of the health care needs of those excluded by TRIPS, and seeks to provide an alternative method of funding pharmaceutical research which respects both rights to intellectual property, and to basic essential medicines.

Prominent suggested alternative approaches include the Health Impact Fund (HIF) (Hollis & Pogge 2008; Bannerjee et al. 2010), the provision of approval prioritisation vouchers for drugs which address neglected disease (Ridley et al. 2006; Sonderholm 2009), offering prizes or longer term patents for drugs which address neglected diseases (Hubbard & Love 2004; Outterson et al. 2007), or guarantees that drugs will be purchased from a specific manufacturer once developed (Kremer & Glennerster 2004). A list of these alternatives is provided by Jorn Sonderholm, who also enumerates the issues associated with each model (Sonderholm 2010b). While these models are utopian, I mention them here to demonstrate the alternatives to TRIPS are at least theoretically possible, even if they are unlikely to be enacted in the near future.

In the following section I summarise the argument presented in this chapter, noting that the duty to avoid depriving requires a broad range of actions and behaviours from duty bearers in the health care context.

2.9 - Summary

In this section I summarise the arguments presented in this chapter.

I have argued in this chapter that failures to fulfil the duty to avoid depriving can take several different forms, and that the TRIPS regime establishes practices which violate what I have termed the impartiality requirement of the duty to avoid depriving. My goal in this chapter has been to set out what the duty requires of duty bearers in the context of the basic right to health care, and to demonstrate the ways in which the duty can be violated. I have argued that in order to meet the demands of the duty to avoid depriving, it is not enough for duty bearers to merely avoid deliberately malicious action, since deprivation can be caused by carelessness, or the decision to indirectly, yet deliberately, allow harm to be caused to some in order to benefit others. Such deprivations are caused through a refusal to consider the needs and rights of those excluded by the structures we construct (Stewart 2014, p.211).

In order for duty bearers to fulfil the demands of the duty to avoid depriving as it applies to the basic right to health care they must; first, refrain from acting in ways which are deliberately intended to cause deprivation for the sake of deprivation, such as physical assault.[1] Secondly, they must ensure that actions which they perform are conducted in such a way as to minimise as far as is reasonably possible the risk that harm will be caused to third parties as a

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[1] While all agents have duties to avoid depriving, those who are most relevant in the examples mentioned are the legislators and lobbyists responsible for formulating unjust laws, as well as those who wilfully take advantage of them, since these agents are the most involved in the propagation of such laws.

side effect of the given action (conscientiousness). Third, duty bearers must ensure that actions which they undertake, including the establishment of institutional structures, take into account the equal moral status of all persons, and that they not impose high costs in terms of deprivation on third parties in order to generate benefit for a preferred individual or group (impartiality). In some cases, meeting these demands will be relatively straightforward and might only require that minimal precautions be taken to reduce the risk of harm. In other cases, this duty might be extremely demanding, and require extensive restructuring of worldwide institutions such as in the case of the TRIPS regime.

In the case of the TRIPS regime, deliberate decisions to value the financial demands of pharmaceutical innovators over the health and wellbeing of the vulnerable have imposed unjust suffering and deprivation on many (Pogge 2008a; Pogge 2008b). While the importance of rights to intellectual property is acknowledged in this chapter, I have argued that the TRIPS regime places excessive emphasis on such rights and fails to recognise the needs and rights of vulnerable people, and in doing so deprives them of important goods which they need to survive. In doing so, I have described this kind of failure to respect the rights and needs of non-preferred groups as failing to fulfil the impartiality condition of the duty to avoid depriving.

In the following chapter, I discuss the next of Shue's duties, the duty to protect from deprivation, with reference to an issue of great relevance to the TRIPS regime, the problem of infectious disease.

CHAPTER THREE

INFECTIOUS DISEASE AND THE DUTY TO PROTECT FROM DEPRIVATION

> *In this chapter I outline the requirements of the duty to protect from deprivation as it applies to the basic right to health care. In doing so, I note the significance of the harms that can be caused by agent independent hazards, and argue that the restrictions that they can impose on the ability of right holders to enjoy other rights means that they merit a response from the duty to protect from deprivation – something which Shue's original statement of the duty does not make clear. I argue that the practical requirements of the duty to protect from deprivation as it applies to the basic right to health care can be divided into three categories, which I explain in detail.*

In the previous chapter I described the demands of the duty to avoid depriving as it relates to the basic right to health care. I argued that the avoidance of deprivation is a complex objective which requires a broad range of behaviours from duty bearers. In doing so, I argued that many global institutional structures fail to live up to the demands of the duty to avoid depriving by prioritising to excess the rights and financial interests of a wealthy minority over the basic health care needs and rights of vulnerable people. I illustrated this using the TRIPS regime: an important example for discussions of global health care justice due to its profound impact on the lives of many around the world. In prioritising intellectual property rights over rights to basic essential medicines, I argued that the TRIPS regime deprives right holders of medicines to which they are entitled under the basic right to health care.

I also argued that the regime deprives right holders of alternative systems of pharmaceutical research which are focused on the production of low cost generic medicines, to which they are also entitled (Adelman & Baldia 1996; Schulz 2004; Venkatapuram 2011, pp.159–160). As such, it exposes right holders to almost inevitable, extremely severe harm. Consequently, being denied access to basic essential medicines is a significant deprivation, which violates the demands of the duty to avoid depriving.

In this chapter I outline the requirements of the duty to protect from deprivation as it relates to the basic right to health care. As Shue originally defines the duty it is concerned specifically with ensuring compliance with the duty to avoid depriving, and with avoiding the creation of incentives to violate that duty (1996, p.60).[1] However, as I shall argue, the existence of health-related, agent-independent hazards means that focusing exclusively on the actions of agents is insufficient to guarantee attainment of the minimum welfare threshold with which Shue is concerned, or to guarantee enjoyment of any other rights (1996, pp.18–19). Consequently, I argue that in order to provide adequate protection from deprivations of health, duty bearers must

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[1] The duty to protect is also closely related to the duty to aid the deprived, since the extent to which the former is fulfilled will have great bearing on the demands of the latter duty. Indeed, Shue explicitly states that failure to adequately fulfil the duty to protect can lead to ‘virtually Sisyphean duties to aid’ (1996, p.63), and specifically mentions such failures in his statement of the third duty.

not only enforce fulfilment of the duty to avoid depriving, but must also guard against agent independent hazards. Therefore, as it applies to the basic right to health care, the duty to protect from deprivation entails the provision of protective goods, services and behaviours, which collectively protect right holders from deprivations of health.

The goal of this chapter is to argue for an expanded statement of the duty to protect from deprivation as it applies to the basic right to health care, and to identify the requirements of the duty. In doing so, I will also demonstrate the significance of deprivations of health as barriers to the enjoyment of other rights. To achieve these goals I first argue that the original statement of the duty to protect from deprivation does not clearly acknowledge the existence of the full range of hazards which are relevant to the basic right to health care. Second, I argue that agent independent hazards are sufficiently important to necessitate a response from the duty to protect, given the impact of the deprivations that they can cause. Third, I propose an expanded statement of the duty, which affirms the importance of enforcing the duty to avoid depriving, but which also entails the provision of responses to the existence of agent independent deprivation hazards. Fourth, I explain the requirements of the duty to protect from deprivation in terms of three categories of action.

In the following section I set out Shue's original statement of the duty to protect from deprivation, and argue that it does not acknowledge a significant source of possible deprivations of health.[1]

3.1 – Shue's Original Formulation of the Duty to Protect From Deprivation

In this section I argue that Shue's original statement of the duty to protect from deprivation does not explicitly account for a significant source of deprivations of health. To make this claim I first restate Shue's original formulation of the duty to protect. Second, I explain how this formulation of the duty focuses exclusively on preventing deprivations caused by individuals, and thus ignores agent independent sources of deprivation.

Shue defines the duty to protect as follows;

> 'II. To protect from deprivation
>
> 1. By enforcing duty (I) and
> 2. By designing institutions that avoid the creation of strong incentives to violate duty (I).'
>
> (1996, p.60)

Collectively, the two sub-clauses of the duty to protect from deprivation focus on the behaviours of agents, and on preventing the performance of

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[1] Having explained the justification of the duty, and its relationship to the other duties in Shue's triumvirate in chapter one, for the sake of brevity I shall not duplicate that explanation here.

actions which cause deprivation. The first sub-clause of the duty entails the existence of obligations to enforce the duty to avoid depriving (Shue 1996, p.60), while the second demands that institutions not incentivise depriving behaviour (Shue 1996, p.60).[1] Shue states, in the context of the basic right to subsistence, that the duty to protect requires that duty bearers 'protect people against deprivation of the only available means of subsistence *by other people*' (italics added for emphasis) (1996, p.53).[2] Correlatively, he argues that those 'who will voluntarily avoid deprivation that would otherwise be advantageous to them because they know that their potential victims are protected, cannot be expected to behave in the same way when they know their potential victims are without protection' implying again that it is the behaviours of agents with which the duty is concerned (Shue 1996, p.61). This formulation of the duty therefore takes agents to be the only relevant source of deprivations, since it refers only to the provision of protection against agent behaviour.[3]

However, focusing exclusively on managing the behaviours of agents is not sufficient for the duty to protect from deprivation as it applies to the basic right to health care. This is because there are a range of hazards which can cause severe deprivations of health that are independent of agent action. For

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[1] I do not in this chapter further explain the specific details of the sub-clauses of the duty to protect, having done so in chapter one.

[2] Shue also makes a similar statement about the basic right to security (1996, p.52).

[3] As discussed in chapter one, the kinds of goods and institutions required to protect right holders from deprivations caused by agent action include the mechanisms of law enforcement, and 'imaginative legislation and, sometimes long term planning' (Shue 1996, pp.60–62).

example, outbreaks of diseases such as malaria[1], tuberculosis,[2] or diarrheal disease[3] can occur independently of failures to fulfil the duty to avoid depriving such as those discussed in the previous chapter.[4] Similarly, natural disasters are not the result of agent behaviours. Such hazards exist independently of agent behaviour, so it is not clear that they are acknowledged by Shue's original statement of the duty to protect from deprivation. However, as I discuss below, the consequences of outbreaks of disease, or of natural disasters, can be profoundly affected by the prior actions of agents and society as a whole. That is, the way in which societies are structured in terms of the availability of protective and therapeutic services can affect the extent of disease outbreaks, and the severity of the deprivations caused by natural disasters. These kinds of hazards can cause severe deprivations, as I discuss below, which can make enjoyment of any decent life impossible, even in the absence of agent action. Therefore, in order to provide adequate guarantees of the enjoyment of the basic right to health care, and other rights, the duty to protect must also entail the provision of those protective goods in the first instance, as I discuss in the following section.

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[1] There were an estimated 655,000 deaths caused by malaria in 2010, with 91% of those deaths occurring in Africa. Globally, about 86% of deaths caused by malaria occur in children under five (World Health Organization 2011, p.73).

[2] Approximately 32% of the world's population is infected with tuberculosis, there were an estimated 1.87 million deaths from the disease in 1997 (Dye et al. 1999, p.277).

[3] In the twentieth century diarrheal diseases killed between four and twenty million people annually (Ewald 1994, p.67).

[4] That is, it is not necessary for medicines to have been made unavailable by agent failures to fulfil their duties to avoid depriving in order for deprivations of health to be caused by outbreaks of infectious disease.

In the following section, I argue in more detail that the duty to protect from deprivation must entail an obligation to provide the protective services it currently neglects because of the severity of the deprivations which can be inflicted by agent independent hazards.

3.2 – The Significance of Agent Independent Deprivation Hazards

In the previous section I argued that Shue’s original statement of the duty to protect from deprivation does not clearly refer to deprivation hazards which are not related to the behaviours of agents. In this section, I argue that as it applies to the basic right to health care, the duty to protect from deprivation must entail the provision of goods and services which protect right holders from agent independent hazards. I doing so I first argue that agent independent hazards can inflict deprivations of health which can prevent enjoyment of other rights, and any decent life, in the same manner as agent caused deprivations. Second, I argue that agent independent hazards qualify as ‘standard threats’ to wellbeing as a result of their ubiquity and remediability, and the severity of their consequences. Finally, I argue that as a consequence of the threat of these hazards, in order to adequately protect health, the duty to protect from deprivation must protect against both agent related, and agent independent hazards.

First, agent independent hazards are relevant to the duty to protect from deprivation as it applies to the basic right to health care, and demand a response from it, because the harms which they can inflict can make it impossible for right holders to enjoy the substances of their rights.

Consequently, the deprivations caused by agent independent hazards can make it impossible for agents to stay above the 'line beneath which no one is to be allowed to sink' (Shue 1996, p.18). For example, I argued in chapter one that deprivations of health can make it impossible to provide subsistence for oneself, or enjoy rights to security and liberty (Held 1995, pp.192, 194–195; Brown & Pollitt 1996; Nussbaum 2003, pp.41–42; Brock 2009, p.66). While the actions of agents do contribute to the imposition of these barriers, and must therefore be acknowledged as important sources of deprivation,[1] agent independent hazards can impose equally damaging deprivations. For example, certain diseases can reduce individual capacity to work, and to thus acquire subsistence goods (UNAIDS 2003, pp.7, 9, 26). On a larger scale, health deprivations caused by infectious disease can impose major barriers to economic development, hindering national capacity to achieve economic independence, as I discuss in chapter five (Price-Smith 2002, p.98; Sachs & Malaney 2002, p.681). Equally, severe deprivations of health are inherently damaging, independently of the further consequences of such deprivations.

In addition to potentially having extremely severe consequences, agent independent hazards are also a common factor in the lives of many people.[2] Many agent independent hazards are also treatable or preventable given existing medical, or infrastructural, capabilities. While it is unlikely to be possible to prevent all agent independent deprivations, the severity of those

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[1] The way in which social institutions are constructed is a particularly important factor in determining the way in which health and wellbeing are distributed in society for example (Marmot et al. 1978; Wilkinson & Marmot 2003; Venkatapuram et al. 2009).

[2] I noted the number of people affected by various types of infectious disease above. However, see also (Mathers et al. 2008, p.72).

deprivations can be ameliorated, and risk can be significantly reduced. For example, improvements in social infrastructure, such as better housing (Ewald 1994, pp.53–54), better warning systems, better sanitation systems (Daniels 2008, p.142), vaccination programmes (Vitek & Wharton 1998; Poland & Jacobson 2011), sexual health services (Viravaidya et al. 1996, p.24), public shelters and health care provision (Hurley et al. 1997, p.1797) can all significantly reduce the impact of natural disasters and infectious disease. This is illustrated by the increased harms suffered by poorer people,[1] who typically lack access to those systems which increase resilience against deprivation in the event of agent independent harms, when compared to their wealthier counterparts (McMichael et al. 1996, pp.8, 61, 125; Pelling 2003, p.3).[2]

Although these kinds of preventative measures do not provide perfect guarantees of protection, they do reduce the likelihood that major deprivations will be suffered by those who are vulnerable to the occurrence of natural disasters.[3] That is, it is possible to reduce the severity of the outcome

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[1] Persistent social failures to prevent or ameliorate poverty can exacerbate the increased risk of harm from disease faced by poorer people, highlighting the importance of protecting against agent related hazards (Eachus et al. 1999; Farmer 1999, p.11; Price-Smith 2002, pp.40–422; Pearce et al. 2010; Venkatapuram 2011, p.7; Yilmaz & Raynaud 2013).

[2] Amartya Sen's claim that no famine has ever occurred in a 'functioning democracy' is also relevant here, since the social factors contributing to the occurrence of this type of 'natural' disaster appear to outweigh the environmental ones (Sen 2010, p.342).

[3] It is worth noting that while an absolute guarantee of protection against the threat of infectious disease, natural disaster, or other agent independent sources of deprivation is impossible, it is also impossible (or at least extremely improbable) to provide this kind of guarantee for agent related sources of deprivation, a point Shue acknowledges (1996, p.61). In each of these kinds of case, providing absolute guarantees of protection from harm is both impossible and unnecessary according to the basic rights model. Protection can be extended to deprivations caused by new sources, but that protection need not be

of natural disasters, even if it is not possible to prevent the disaster itself. Similarly, in the case of infectious disease, while it may be impossible to ever fully eradicate all pathogenic sources of deprivation, it is possible to minimise the likelihood that right holders will be seriously affected by the most common threats to health. As such, it is possible to achieve significant reductions in vulnerability to severe deprivation through the provision of basic social and medical services even when complete protection is impossible. Further, such protections can also be relatively inexpensive (Dasgupta 1993, pp.92–93; Hotez et al. 2009).[1] Many agent independent hazards therefore fulfil each of the three aspects of Shue's definition of 'standard threats' – they are 'ordinary [or common], and serious but remediable' (1996, p.32). Therefore, at least some agent independent hazards qualify as standard threats of the kind with which the basic rights model is concerned, and thus merit consideration by the duty to protect.

As noted in the previous section, the original statement of the duty to protect from deprivation does not obviously entail duties to protect right holders from deprivations caused by agent independent hazards such as infectious disease or natural disasters.[2] However, I have argued in this section that some agent independent hazards are virtually ubiquitous threats to wellbeing, and

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absolute or perfect, it is enough to provide reasonable protection against these likely harms to health.

[1] It should also be noted that perfect protection from deprivation is not required by the basic rights model, all that must be guaranteed is reasonable protection against standard threats (Shue 1996, p.33). As noted earlier in this thesis, Shue states that '[t]he fulfilment of both basic and non-basic moral rights consists of effective, but not infallible, social arrangements to guard against standard threats' (Shue 1996, p.34).

[2] I noted Shue's emphasis on deprivations caused by 'other people' in the previous section (1996, p.53).

that it is possible to at least ameliorate the consequences of such hazards, thus protecting right holders from severe deprivation. As such, some agent independent hazards qualify as what Shue describes as standard threats to wellbeing, and thus demand recognition, and a response from the duty to protect from deprivation. Therefore, in order to provide adequate ‘social guarantee[s]’ of the ‘actual enjoyment’ of health and other rights (Shue 1996, p.13), and enable the attainment of a ‘decent life’ (Shue 1996, p.18), it is necessary to expand the duty to protect from deprivation in order to account for the existence of agent independent threats to health. Expanding the scope of the duty in the manner I propose in the following section will enable the duty to account for the existence of agent independent hazards. It also makes explicit the existence of obligations to provide protection against such hazards.

3.3 – Expanding the Duty to Protect From Deprivation

In the previous sections I made four related claims; first, that Shue's original statement of the duty to protect does not provide a clear account of the full range of potential sources of deprivation which are relevant to the basic right to health care and its corresponding duty to protect from deprivation. Second, that Shue's emphasis on enforcement of the duty to avoid depriving, and on the behavior of agents is not obviously applicable to the broad range of deprivations that can be caused by agent independent hazards such as infectious disease and natural disaster. Third, that these kinds of hazard pose significant threats to the wellbeing of right holders and can significantly undermine their ability to enjoy the other basic rights or live a minimally ‘decent life’ (1996, p.xi). Fourth, that it is therefore necessary to expand the original statement of the duty to protect from deprivation in order to account for both agent related and agent independent sources of deprivation and adequately guarantee enjoyment of the basic right to health care and all other rights. In this section I propose an expanded statement of the duty to protect which accounts for both agent related, and agent independent hazards.

The original statement of the duty to protect can be expanded relatively simply in order to account for the existence of agent independent deprivation hazards. Effective protection from agent independent hazards requires both direct responses to the existence of such hazards, and the construction of systems which minimise the causes of deprivations. These requirements are therefore closely analogous to the original sub-clauses of the duty which have similar functions. As such, the expanded duty to protect from deprivation can be defined as follows (changes to Shue’s original statement have been italicised for clarity);

> ‘II. To protect from deprivation
>
> 1. by enforcing duty (I), *and guarding against non-agent directed threats to health*, and
> 2. by designing institutions that avoid the creation of strong incentives to violate duty (I) *and which provide protection against likely threats to health*’
>
> (Shue 1996, p.60)

This expanded statement of the duty is not intended to reject the importance of agent related health deprivation hazards. Agent action is an important cause of significant deprivations, as discussed in the previous chapter, and it is important to ensure that the duty requires duty bearers to respond to the existence of agent related hazards. However, the existence of agent independent hazards which can make enjoyment of any other rights or of any decent life impossible means that merely managing agent behaviour is not sufficient to ensure right holders are able to enjoy their other rights as rights. As such, the expanded duty to protect from deprivation is intended to retain a focus on agent related hazards, but to also acknowledge the existence of agent independent hazards, and to demand protective action against them.

Expanding the scope of the duty to protect from deprivation as it applies to the basic right to health care is justifiable because of the ubiquity and remediability of agent independent hazards, and the severity of their potential consequences, as argued in the previous section. Expanding the scope of the duty in the manner I suggest in this section does entail more expansive obligations for duty bearers to fulfil. However, these obligations are limited by Shue's assertion that the basic rights provide only reasonable guarantees against the standard threats to deprivation. Therefore, the protection provided by the basic right to health care will extend only as far as can be achieved through the imposition of reasonable duties on duty bearers, as discussed in chapter one.[1] The provision of protection against agent independent hazards is also implied by Shue's comment that 'we have very little excuse for allowing so many poor people to die of malaria' (1996, p.33). As such, while Shue does not explicitly assert the importance of agent independent sources of deprivation in his original statement of the duty to protect from deprivation, he implicitly recognises the importance of providing at least some health care goods to those in need, regardless of the source of the deprivations that affect them.

Therefore, there are good reasons to endorse expanding the original definition to refer to such sources of harm. Since the threat of deprivation caused by agent independent harms like infectious disease is so prevalent, and since the consequences can be so severe as to preclude enjoyment of other rights and a 'decent life' (Shue 1996, p.xi) in the same way as agent related deprivations, failure to acknowledge the importance of agent independent sources of deprivation undermines the guarantees offered by the basic right to health care. As such, in order for the duty to protect from deprivation as it relates to

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[1] I provide a metric for defining these reasonable obligations in the following chapter.

the basic right to health care to adequately guarantee the ability of right holders to enjoy any decent life it must respond to sources of deprivation which are not related to agent behaviour in addition to providing the kinds of guarantees described by Shue.

In the following sections I discuss three categories of intervention behaviour required by the expanded theoretical demands of the duty to protect as discussed in this and the preceding sections.

3.4 - Fulfilling the Duty to Protect From Deprivations of Health

In the previous sections I have made four claims; firstly, that the duty to protect from deprivation is essential for fulfilment of the basic right to health care. Secondly, that Shue’s original statement of the duty to protect from deprivation does not obviously refer to agent independent health deprivation hazards, though he elsewhere argues for the moral relevance of such hazards. Thirdly, that the original statement of the duty can be amended only slightly in order to account for the increased requirements of the basic right to health care, and fourthly, that agent independent sources of deprivation such as infectious disease and natural disaster are relevant to the basic right to health care. In the rest of this chapter I propose an outline of the practical requirements of the duty to protect from deprivation as it relates to the basic right to health care. I also explain how different types of agent can have different specific responsibilities under the duty to protect from deprivation. In this section I first identify three categories of practical intervention which I argue in the following sections are collectively required to provide right holders with adequate protection from deprivations of health. I discuss these interventions with reference to their role in protecting right holders from infectious disease, though I also suggest how these categories apply to other hazards.

First, the actions and services required to adequately protect right holders from health deprivation hazards can be broadly classified as falling into one of three interrelated general categories; first, social-infrastructural interventions; second, medical interventions; third, participatory-behavioural interventions. Each of these interventions operates in different ways, and all are essential for the provision of adequate guarantees of protection. These interventions operate in different ways to protect from deprivations of health; some protect 'directly' by protecting specific right holders from the threat of health hazards, while others protect indirectly, by providing the infrastructure which enables the delivery of more obviously prophylactic measures. Concurrently, some of the requirements of the duty to protect from deprivation are focused on the behaviours of individual agents, while others entail complicated, cooperative action from groups of agents.

In the following sections, I explain the specific types of intervention which fall into each category in detail, and explain their importance for the fulfilment of the duty to protect from deprivation. I examine the practical requirements of the duty to protect from deprivation in terms of these categories largely for purposes of clarity. By separating out the requirements of the duty into three distinct categories, they can be examined more closely, their requirements made more explicit, and the relationships between each type of intervention made more obvious. Doing so also highlights the significant complexity of the requirements of providing protection against the standard threats to health, as I argue below.

In each of the three following sub-sections I examine one of these three categories of protective intervention as it relates to infectious disease in order to illustrate the importance of these categories of intervention for the duty to protect from deprivation. In analysing each category I also explain how responsibility for fulfilling them can be applied to different types of agent. The first category of intervention I discuss requires the provision of needed social infrastructures for the protection of health.

3.4a – Protective Social Infrastructures

In this section I argue for the importance of what I term 'social-infrastructural' interventions which protect right holders from standard threats to their health. To make this argument, I first argue that this kind of protective intervention has the dual role of providing the structures which facilitate the delivery of more obviously prophylactic interventions, and directly protecting against certain large scale threats to health. Second, I suggest examples of the kinds of intervention that would be included in this category, and explain their importance to the duty to protect from deprivation as it relates to the basic right to health care. Third, I argue that the importance of this category of interventions is derived from this duality of purpose. Finally, I argue that different kinds of agent can have different responsibilities to contribute to the provision of such interventions, and offer some examples of how these responsibilities can be fulfilled.

Social-infrastructural protective interventions are those which provide non-medical protections to right holders. I use the term social-infrastructural intervention because they confer protection upon groups of people, and provide the mechanisms by which other protective interventions can be provided. This category of interventions has two roles;

1. To enable the delivery of effective medical and behavioural interventions for the protection from deprivations of health;
2. To provide social services and infrastructures which directly prevent deprivations of health by addressing deprivation threats

Given the twin roles of the social-infrastructural category, interventions which fall into the category can be of two types; first, infrastructural interventions which enable the delivery of other protective services include things like research and development of new medicines and medical procedures (Venkatapuram 2011, pp.159–160), the provision of publicly accessible health care services (Farmer 1999, p.11; Davis et al. 2014), and systems which train medical professionals.[1] This is not an exhaustive list, but it does indicate the range of facilities necessary to ensure that the other

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[1] It might be objected that privately funded systems of pharmaceutical research and development, and health care provision actually provide the best outcomes in terms of protecting health. However, as was discussed in the previous chapter, and elsewhere (West-Oram 2013), private systems of pharmaceutical research are often extremely inefficient (Hubbard & Love 2004), as are private health care systems, which are also expensive and exclusionary (Schoen et al. 2010; Anderson et al. 2012).

practical requirements of the duty to protect may be fulfilled. The importance of this type of deprivation is derived from the role of these systems in enabling the delivery of the more direct practical requirements discussed in the following sections.[1]

The second function of the social-infrastructural category of interventions provides systems which directly protect right holders from hazards which are best addressed through large scale, group focused intervention systems; that is, through interventions which are not directed at specific individuals, but rather at groups. For example, preventing outbreaks of severe diarrhoeal disease is achieved most effectively through the provision of public infrastructure such as education and sanitation systems (McMichael et al. 1996, pp.96–100, 133; Brock 2009, p.120; Bhutta et al. 2013, p.1419).[2]

Similarly, poverty reduction can also have a significant impact on reducing the threat of disease and the severity of harms suffered, since economic deprivation can be a major risk factor for increased harms caused by

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[1] It may be argued that to distinguish the structures which enable the delivery of other systems for the protection of health is overly complicated, and that this requirement should instead be taken to be an implicit aspect of the other two categories. However, while making the above distinction does add complexity, this complexity is not unwarranted. Distinguishing between services and structures which protect against deprivations and those which enable that protection to occur demonstrates the range of practical interventions necessary for the duty to protect more clearly. Aggregating ‘enabler’ interventions with the protective interventions which they support may be marginally simpler, but doing so does not adequately portray all the practical requirements of the duty to protect. Secondly, the kinds of structures which support the medical and behavioural categories of intervention are not in themselves medical or behavioural interventions, they are structural or social systems which enable effective delivery of interventions which are more directly involved with sources of deprivation. As such, classifying ‘enabler’ interventions under the social-infrastructural category is more appropriate, and more accurately reflects the nature of these interventions.

[2] See also (Chopra et al. 2013; Gill et al. 2013; Fischer Walker et al. 2013).

deprivations of health (Ryan 1971, p.170; Banta 2002; Pelling 2003; Venkatapuram et al. 2009; Buchman 2012; Yilmaz & Raynaud 2013). Other structural interventions might also include systems which guarantee adequate nutrition (Dasgupta 1993, p.12), clean drinking water (Barnett & Adger 2003, p.322; Brock 2009, p.120), and safe, climate appropriate housing (Ewald 1994, p.54; McMichael et al. 1996, p.61). These kinds of intervention are not obviously medical, but providing them to right holders can significantly reduce the risks faced by vulnerable persons and contribute effectively to protecting everyone from deprivations of their health. As such, while the kinds of intervention in this category are social, systemic, and infrastructural rather than medical, they can carry significant medical benefits.

The two foci of this intervention category therefore differ in the nature of their relationships to sources of deprivation. The first focus is at one remove from sources of deprivation because it entails the provision of services and structures which enable the delivery of the other types of protective intervention. In contrast, the second focus is more directly involved with protecting right holders, since it entails the provision of systems which protect, rather than with systems which enable protection. Interventions which fall under each focus are both essential for the provision of adequate protection to right holders, and thus make this category of interventions vital for the adequate fulfilment of the duty. Therefore, the importance of the social-infrastructural protective category of interventions is derived from its dual role in enabling the delivery of more obviously protective health care systems, and in providing non-medical services which provide effective protection to groups of right holders.

As has been argued elsewhere (Widdows & West-Oram 2013a, pp.234–237), the complexity and scale of the infrastructure needed for the effective long term delivery of global health care interventions is extremely demanding. As such, providing the necessary infrastructure is likely to be beyond the ability of individual or even private corporate agents. Further, relying on the private actions of individual agents and their associations is unlikely to generate the outcomes necessary for the protection of health, as has also been discussed elsewhere (Widdows & West-Oram 2013a; West-Oram 2013, pp.240–241). Instead, given the scale of the infrastructure required to ensure the effectiveness of these systems, the agents most suitable for fulfilling the social-infrastructural requirements of the duty to protect are likely to be national governments, or intergovernmental institutions, such as the United Nations or World Health Organisation (Nickel 1993, pp.80–82). This is particularly true given the limited accessibility and effectiveness, and significant cost inefficiency of privately funded health care systems (Schoen et al. 2010; Schoen et al. 2011). However, individual and corporate agents do have responsibilities to contribute to the provision of these interventions indirectly, as I argue in more detail in section 3.4c.

In this section I have argued that social-infrastructural interventions are necessary for fulfilment of the duty to protect from deprivation because they provide the method of delivering or enabling the requirements discussed in the following two sections, and provide social services and institutions which directly protect health.[1] Delivery of interventions of this type is primarily the responsibility of governmental or intergovernmental agents, because of their complexity and scope, though as I argue below, individual and corporate agents have duties to contribute indirectly to the provision of this kind of intervention.

In the following section I argue for the importance of providing reactive medical aid, which might plausibly be thought to be a function of the duty to aid the deprived, to victims of infectious disease in order to limit the spread of infection, and protect currently unaffected third parties from harm.

3.4b –Medical Interventions: Treating Victims to Protect Third Parties

In this section I argue for the importance of the second category of interventions required by the duty to protect from deprivation – prophylactic medical treatments. In doing so, I first outline the importance of medical treatments generally, and argue that protective medical treatments can be divided into two categories. Secondly, I explain the importance of 'treating to protect' in terms of the benefits it generates for third parties, with reference to the problem of antimicrobial resistance. Third, I suggest ways in which the argument presented here, which largely relates to infectious disease, can be applied to other kinds of health deprivation. Finally, I argue that providing

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[1] This second type of institution is closely related to the second sub-clause of the original formulation of the duty to protect since both focus on the provision of structures which prevent the occurrence of deprivation.

this kind of protective intervention is primarily the responsibility of governmental agents.

First, it is possible to distinguish at least two categories of medical intervention required by the duty to protect from deprivation which are intended to protect right holders from deprivations of health. Firstly, proactive, direct medical interventions, such as vaccination, provide protection against a specific disease to the specific individual treated before the occurrence of deprivation, and if enough persons are also treated, to all members of a vaccinated community (Anderson & May 1985; Coggon 2012, p.43). Secondly, reactive, indirect medical interventions function by providing treatment to those who are already the victims of infectious disease in order to protect third parties. Where the first type of intervention is concerned with protecting those treated (and their compatriots, to a lesser extent), this second type of intervention focuses on protecting those currently unaffected from the threat posed by their infected, and infectious, compatriots.[1] In this way, proactive, direct interventions treat person X to protect person X, while reactive, indirect interventions achieve the objective of protecting unaffected group X by treating infected person or group Y. Both types of intervention are required by the duty to protect since it will not always be possible to prevent the occurrence of diseases which carry a threat of infection. However, since I discuss vaccination programmes in the

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[1] The imposition of quarantine, or variations of it, on individuals suffering from particularly infectious or dangerous diseases may also be an appropriate measure in some circumstances because of the threat posed by certain infectious diseases (Battin et al. 2009, p.283). Obviously however, such practices are not directly medical, and I shall not discuss them in detail in this section.

following section, I shall focus here on the importance of the second, reactive category of medical interventions for the protection of health.

Second, given that human beings can be both the ‘victim and vector’ of infectious disease (Battin et al. 2009, pp.9–10), providing treatment to infected individuals can be an essential aspect of protecting third parties from contagion. For example, as a result of its communicability, people with tuberculosis present a threat (unintentionally) to the wellbeing of those in their close proximity.[1] Ignoring this threat and failing to provide treatment or other prophylactic measures would therefore expose the currently uninfected members of the group to a significant, preventable harm, thereby failing to fulfil the duty to protect from deprivation. However, successful treatment of tuberculosis (which can be complicated and lengthy) minimises the risk of transmission to others by (eventually) eliminating one human vector of the disease. Further, patients undergoing treatment are also significantly less infectious than their untreated counterparts (Ahmad & Morgan 2000, p.157).

Prior to outbreaks of tuberculosis, prophylactic measures are an important part of a medical response to the threat of disease, but providing treatment to victims of the disease is also important since it reduces patient infectiousness

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[1] Roughly one-third of humanity is infected with tuberculosis (World Health Organization 2010), and between 1990 and 2000 there were roughly 30 million deaths from the disease (Farmer 1999, p.212). Further, it is predominantly citizens of poor countries who are most at risk (approximately two-thirds of all cases occur in Africa and South-East Asia) (World Health Organization 2010), though wealthy countries are not immune to it. The disease also has great potential for latency (N. H. S. Choices 2011), meaning that it can remain dormant for years, until the carrier’s immune system is no longer able to contain it, and carries significant risk of evolving resistance to commonly used medicines (Faustini et al. 2006; Fidler et al. 2007).

and contributes to reducing the duration and scale of the outbreak, thereby minimising the risks for unaffected persons. As such, providing treatment to those with infectious diseases, and requiring the use of that treatment,[1] is an important requirement of the duty to protect. This kind of intervention is reactive, and provides aid to a harmed person in order that others are not harmed as a result of the initial deprivation.[2] Effective treatment is also important long term because it serves to slow the development of drug resistant strains of disease (though providing no treatment at all would also serve the same purpose) (Faustini et al. 2006), and minimises the risk of disease re-emergence (Vitek & Wharton 1998), thus protecting current and future generations from potentially more dangerous types of existing pathogens (L. B. Reichman 1996; Reichman 1997).

The evolution of drug resistant strains of disease is a growing global problem of great importance (Byarugaba et al. 2001; Bronzwaer et al. 2002; Byarugaba 2004). For example, drug resistant strains of tuberculosis are harder, and more expensive to treat, and are thus more dangerous to those who are exposed to them.[3] The drugs used to treat multi-, and extremely drug resistant strains of tuberculosis (MDR-, and XDR-TB respectively) are also

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[1] See for example, (Barnhoorn & Adriaanse 1992; Morse 1996; Mitty et al. 2002). I argue for the duty to participate in treatment programmes in the following section.

[2] One cannot of course, argue that treating a broken leg sustained in a automobile accident protects anyone, but we can, in light of this objection, recognise that treating to protect might be analogous to measures instituted after the fact of such accidents (better traffic enforcement for example) which are designed to protect those who are also vulnerable. The key point is that treating to protect is the kind of intervention which emphasises action after the fact of harm designed to protect others from similar harms.

[3] See for example (Iseman 1993; Wise et al. 1998; Cosgrove 2006; Welch et al. 2007; Cars et al. 2008).

significantly more toxic, producing far worse side effects than frontline drugs (Battin et al. 2009, p.152). Further, studies have shown that the evolution of drug resistance, particularly in the case of tuberculosis has been actively, if unintentionally, selected for by failures in public policy and health care provision (Farmer 1999, p.247; Ormerod 2005, p.17; Faustini et al. 2006, p.158). It should therefore be recognised that failures to provide effective treatment for infectious disease not only fail to provide the care to which the individuals affected are entitled, they also fail to adequately protect other individuals long term by accelerating the evolution of far more dangerous threats to health than had previously existed.[1] For this reason, provision of effective treatment of disease is an essential part of the duty to protect, since by responding effectively to these threats to health, vulnerable third parties can be protected from the threat posed by their compatriots, while the risk of yet worse harms occurring can be reduced.

Third, this concept of providing medical treatment to protect can be expanded to other health deprivation contexts in which the duty to protect from deprivation can be said to apply. Since this category of intervention is directly focused on responding to threats to health, general principles about the kinds of intervention required by the duty to protect from deprivations of

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[1] For example, Paul Farmer notes that between 1968 and 1978 in New York City, funding for tuberculosis (TB) control and treatment was reduced by up to $17 million annually. As a result, between 1979 and 1992, rates of tuberculosis increased dramatically, with a concurrent increase in the rate of MDR and XDR-TB (Farmer 1999, pp.230–231). As a result, the savings of around $200 million achieved through cutting budgets led to additional costs of over $1 billion, spent to try and control drug resistant strains of the disease which had developed in the years when treatment was less accessible (Farmer 1999, pp.230–231).

health can be established by identifying other possible interventions which also respond directly to the presence of health threats. For example, in the case of protection from injury it may be decided to impose stricter speed limits and traffic laws, or make physical changes to road surfaces in order to minimise the risk of injuries caused by traffic collisions. For example, increased police focus on ticketing drivers who break the speed limit as a means to generate town revenue has been found to reduce the number of traffic accidents and injuries in the United States of America (Makowsky & Stratmann 2011, pp.863, 887–888).[1] This kind of intervention is also a kind of social-infrastructural intervention as discussed in the previous section, yet it shares with the idea of therapeutic medical interventions the fact that both types of treating to protect are reactive to the presence of a threat. In both contexts, the action taken by relevant duty bearers is 'threat focused' and initially affects the hazard, whether that is a human vector for an infectious disease, threat of injury, or an unsafe stretch of road. In this manner it is possible to extend the arguments I make in this section to the wider context of protecting health more generally.

Fourth, like the non-medical interventions examined in the previous section, responsibility for providing medical treatments for protective purposes is primarily held by governmental agents, as put by Nickel, they are the 'primary addressees' of the basic right to health care in this context (1993,

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[1] For additional public health benefits associated with road safety see also (Elvik 2001; Blincoe et al. 2002, p.1; Australian Transport Council & Australian Transport Safety Bureau 2006, p.1).

pp.80–81). This is because governmental agents have the power, and importantly, the legitimate authority to coordinate the delivery on a large scale of the medicines needed to provide treatment, and thus protection to large numbers of people. It should be noted however, that where governments lack the ability to respond effectively to hazards of this kind, or where outbreaks transcend national boundaries, intergovernmental agents can also have responsibilities to act. Large scale responses are often necessary because of the scale of outbreaks of infectious disease (World Health Organization 2014b), and the complexity of delivering treatments that will have an effective prophylactic impact. Finally, indirect responsibilities to contribute to the provision of this kind of intervention are owed by individual and corporate agents, though these responsibilities will largely entail the contribution of funds to pay for them, and compliance with governmental policy. In Nickel’s terms, individual and corporate agents are thus ‘secondary addressees’ of this requirement (1993, pp.80–81).

Providing treatment to the victims of infectious disease in order to protect third parties is one of many possible responses to the threat of contagion. However, other methods of providing protection to right holders may also be necessary depending on the context in which potential threats emerge. For example, as noted above, the imposition of quarantine on persons suffering from extremely communicable, dangerous diseases may in some cases be warranted. Similarly, outside of the context of infectious disease, addressing the threat posed by environmental hazards may be an effective way of providing protection from other agent independent sources of deprivation.

Importantly, the provision of treatment to victims of infectious disease acknowledges their status as both ‘victim and vector’ of contagion (Battin et al. 2009, p.481), and enables a more complete response to the presence of infectious threats to health.

In the following section I set out the third practical requirement of the duty to protect, which obliges duty bearers to actively participate in protecting the health of other persons through engagement with social projects, such as the provision of vaccination and treatment programmes, for the protection of health. I discuss this requirement of the duty in light of participation in vaccination programmes.

3.4c - Protecting by Participating in Public Health Measures

In this section I argue for the importance of participatory-behavioural interventions for the duty to protect from deprivation. In doing so I set out the ways in which individual agents can pose a threat to the wellbeing of other persons. To make the argument for the importance of participatory-behavioural interventions I first explain the difference between this category of intervention and those discussed above, in doing so I argue that this category of intervention is primarily the responsibility of individual agents. Second, I argue for the importance of this category of intervention. Third, I illustrate this importance with reference to a requirement to participate in vaccination programmes,[1] and suggest that such mandatory participation is an essential requirement of the duty to protect from deprivation as it applies to the basic right to health care. Finally, I suggest parallels between the importance of participation in vaccination programmes and that of other health deprivation hazards.

First, the interventions discussed in the two preceding sections each focus on the provision of services, structures, or goods, which right holders and duty bearers can use to protect themselves and others from deprivations of health. In contrast, the interventions discussed in this section do not involve the construction of institutions, but focus instead on the behaviour of individuals and their participation in, and use of, institutions and services. In this way, the third practical requirement of the duty to protect is more focused on individual agents and their responsibilities, and serves to enable the delivery and construction of the services and systems discussed in the previous sections. As such, the relationship between this category of intervention and the others is reciprocal; for the systems discussed above to function effectively, agents must participate in them, and agents must have access to certain important services if they are to effectively contribute to the protection of their fellows. For this reason, individual agents have the most responsibility for delivering participatory-behavioural interventions, though

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[1] It will be noted that I do not in this section analyse any requirements to provide vaccination or other preventative services, or to enable participation in them. This may seem like an oversight, since it is unreasonable to expect individuals to participate in public health programmes to which they do not have access (Battin et al. 2009, p.270). However, in the previous sections I discussed in detail the necessity of providing accessible medical and social infrastructures for the protection of health, and it would be redundant to discuss these issues again here.

corporate agents can have responsibilities to participate through the provision of funding.

Second, in order for the systems proposed in the previous sections to be effective, they require the active participation of individual and corporate agents. Therefore, obligations to participate in health protecting systems, and to contribute to their efficacy, are an essential component to the duty to protect from deprivation as it applies to the basic right to health care. In the absence of the active participation of individual and corporate agents the efficacy of the protective systems discussed in the previous sections is likely to be severely reduced, as is the ability to provide such systems. For example, in the previous section I noted the importance of providing medical treatment to those infected with certain infectious diseases in order to protect as yet uninfected third parties. In this context, if medicines are provided, but patients do not take them, the best distribution system in the world will have little success in preventing the spread of disease - hence the importance of directly observed therapy (DOTS) for the control of infectious disease and the restriction of the evolution of antimicrobial resistance (Morse 1996; Mitty et al. 2002; Flanigan et al. 2005). Therefore, active engagement on the part of agents is an essential requirement of the duty to protect from deprivation as it applies to the basic right to health care.

This is not to suggest that those who fail to adhere to their often complicated, and prohibitively expensive, drug regimes are necessarily guilty of moral wrong, since other factors can make adherence to a drug regime extremely difficult. For example, high prices of antibiotic medicines can make it impossible for poor people to follow the instructions of doctors if they are unable to afford prescribed medicines (Farmer 1999, pp.235–240). Instead, my aim is merely to show that without active, effective participation from agents, protective infrastructures are unlikely to enjoy great success in limiting the spread of infection.

Third, I use vaccination as the main example in this section because of the way in which participation levels so directly correlate to the efficacy of disease prevention efforts (Etkind et al. 1992; Mossong & Muller 2003, p.4597; Battin et al. 2009, p.34).[1] There are four key benefits which arise from the efficacy of vaccination programmes which recommend them as vital aspects of the duty to protect from deprivation. First, vaccinated persons are protected from the diseases against which they have been vaccinated, and no longer pose a threat of infection for those diseases to their compatriots thus reducing the general risk of infection (Battin et al. 2009, p.481). This is achieved by increasing levels of immunity in a given group, as a consequence of which vaccination can render the transmission rates of vaccine preventable diseases unsustainable, thus eliminating the disease as a threat from a given region (Fine 1993, p.265). In this way, effective vaccination programmes which achieve sufficient participation levels can extend protection even to

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[1] Other potential examples outside of the context of infectious disease, could include adhering to motor vehicle speed limits and driving safely (Meier & Morgan 1982; Steinbock 1985).

those who do not (Sinal et al. 2008; Salmon et al. 2009)[1] or cannot (Salmon et al. 1999, p.47) participate, and to future generations, a result known as herd immunity (Anderson & May 1985; Fine 1993, pp.265, 268).[2]

The second aspect of the argument for obligations to participate in vaccination programmes and social projects is that participating imposes relatively small costs on duty bearers while conveying significant benefits to those they protect (Sanders & Taira 2003, p.37). For example, vaccination has been described as ‘one of the most successful and cost-effective health interventions ever’ (Expanded Programme on Immunization of the Department of Immunization, Vaccines and Biologicals 2006, p.3) since successful participation in vaccination programmes virtually eliminates the threat posed by a specific disease. Not all persons are medically capable of participating in vaccination programmes, and so rely on the participation of others for protection from vaccine preventable threats (Salmon et al. 2005, p.778).

The third valuable consequence of effective vaccination programmes is that in some cases vaccination can reduce the risk not only of infection by a specific disease, but also of secondary risks such as some forms of cancer (Garnett 2005). This is shown particularly clearly with the example of the development of the vaccine for the Human Papillomavirus (HPV). HPV is sexually

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[1] I have discussed non-medical objections to mandatory participation in vaccination programmes elsewhere (West-Oram 2013) and argued that none of them represent sufficient grounds for exemption from the duty to participate in vaccination programmes.

[2] Vaccination also confers benefits on future generations, since it reduces the number of people who are potential carriers of a pathogen, and thus reduces the risk that a given disease will persist over time, thus reducing the threat posed to potentially vulnerable future persons (Vitek & Wharton 1998).

transmitted infection which once acquired can lead to cervical cancer in later life (Garnett 2005). Therefore, vaccination against HPV can not only protect against HPV itself, but also against cervical cancer, which is far more expensive to treat (Sanders & Taira 2003, p.37). Similarly, if left untreated, Schistosomiasis can cause bladder cancer (Abdel-Wahab 1982, p.146), and increase risk of sexually transmitted infection, including HIV (Kjetland et al. 2006, pp.593–594; Hotez et al. 2009). Therefore, preventing such infections, or treating them quickly can reduce the risk of the occurrence of more severe harm which are more costly to treat long term. Fourth, effective vaccination programmes prevent the re-emergence of previously controlled diseases. In contrast, failure to do increases the risk that previously controlled threats will re-emerge to cause significant harm (Vitek & Wharton 1998, p.539; Feikin et al. 2000; BBC News Online 2009).

As a consequence of these features of effective participation in vaccination programmes, it is reasonable to argue that participation is required of those medically able to do so by the duty to protect. This is because by participating, individuals contribute towards the protection of their vulnerable compatriots.[1] Conversely, refusal to participate in vaccination programmes when one is medically able to do so is to expose others to increased risk of severe harm, and to thus fail to take reasonable steps to

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[1] For an examination of the impact on groups with large numbers of ideological objectors to vaccination see (Etkind et al. 1992; Mossong & Muller 2003; Battin et al. 2009, p.34).

protect them from that harm, an issue I have discussed in more detail elsewhere (West-Oram 2013, p.243).[1]

Finally, vaccination is analogous in a number of ways to other interventions (which may be non-medical) intended to protect health more generally. By complying with, or participating in, social, as opposed to medical, projects, such as considerate smoking behaviours (Mannino et al. 2003; Gallo et al. 2010; Chen et al. 2013), individuals can contribute to the protection of others from the threat which they pose to them. Adherence to these kinds of behavioural requirements allows agents to protect their fellows by reducing the risk of particular health deprivations occurring through the reduction of the prevalence of risk carrying hazards. They can also reduce risks to themselves and in doing so contribute to minimising any potential future treatment costs. In contrast failure to participate exposes third parties to great risk of harm.

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[1] In discussing the importance and justifiability of obligations to participate in vaccination programmes I argued that refusal to participate cannot be justified on philosophical or ideological grounds, because doing so exposes third parties to great risk of harm (West-Oram 2013). It might be objected that religious freedom is a vitally important right which should entitle duty bearers to refrain from participating in services which they deem immoral, such as vaccination, a claim which is the subject of intense debate (Salmon et al. 1999; Feikin et al. 2000; Salmon et al. 2009). However, a right to ideological exemptions from participation in vaccination programmes cannot be justified as a basic right because it is possible to enjoy other rights in its absence. In contrast, without a reasonable guarantee of protection against vaccine preventable disease, something which is undermined by ideological exemptors, it is not possible to enjoy other rights. Therefore, a right to protection from vaccine preventable disease which demands participation in vaccination programmes by all medically capable persons is part of a basic right to health care, while a right to exempt oneself from such programmes on ideological grounds is not. However, as noted by Salmon et al., demanding participation in vaccination programmes must be done carefully in order to avoid provoking increased resistance from ideological objectors (2005, p.781; West-Oram 2013, pp.245–246).

Consequently, the argument for participation in vaccination programmes is two-sided, since refusal to participate does not merely fail to protect, it also increases the risk of harm to other persons and deprives them of reasonable protections from avoidable harms. This argument can be summarised as follows; firstly, protecting oneself from certain kinds of health deprivation can have a protective effect on the welfare of other persons. Secondly, there are many actions which may seem self-regarding but which can have severe consequences for other agents; for example, dangerous driving, smoking and refusal to participate in vaccination programmes. Thirdly, where one's actions can have negative side-effects on the lives of others, one has a responsibility to take action to minimise those risks.[1]

The examples offered so far have focused on the responsibility of individual agents to participate in the provision of protective measures for the preservation of the health of third parties. I also noted at the start of this section that corporate agents can also have duties to participate in such systems, though it is unclear how a corporate entity such as a multinational corporation could directly participate in a vaccination programme. However, the vaccination example provides a useful analogy for the importance of duties to contribute towards the funding of essential health care services. This analogy also clarifies how corporate agents can have participatory duties.

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[1] This echoes the requirements of the conscientiousness condition as discussed in the previous chapter.

I argued above that one of the main reasons for participating in vaccination programmes is that by doing so, duty bearers can extend protection to those who are unable to participate for medical reasons. This feature of vaccination is importantly similar to the funding through taxation of health care services for those unable to contribute financially to their cost. In both cases, economically or medically disadvantaged people receive protection or assistance from their compatriots which enables them to enjoy a minimally decent life despite their vulnerability. While corporate agents cannot directly participate in vaccination programmes for example, they can contribute to the funding of such programmes, and to other public health efforts.[1]

In contributing financially to the cost of publicly accessible health care services individual and corporate agents can contribute to the protection of right holders, and minimise the economic costs associated with outbreaks of infectious disease (UNAIDS 2003). As such, the payment of fair, proportionate taxes to fund health care services for all can be seen as analogous to participation in vaccination programmes, and is a participatory behavioural requirement of the duty to protect from deprivation. This means that corporate agents, such as businesses can have behavioural obligations under the duty to protect, something that would be impossible if these duties were limited to things like participation in vaccination programmes for example. A corporation cannot receive a vaccination, nor can it drive safely

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[1] It can also be argued that individual agents have similar ‘financial participatory’ duties in addition to their duties to participate directly in protective public health measures (Nickel 1993, pp.81–82).

or smoke considerately (though it can dispose of any waste it produces conscientiously), but it can contribute through fair taxation to the provision of health care services which will protect those unable to protect themselves in a similar fashion to the more directly participatory behaviours of individual agents.

In this section I have argued that the duty to protect from deprivation requires individual and corporate agents to participate in social programmes and institutions designed to protect health.[1] This category of requirements is necessary for fulfilment of the duty to protect because active engagement with the means to protect health is essential for those systems to provide protection to the vulnerable. In using the example of vaccination I argued that because participation in vaccination programmes reduces the risk of the spread of infectious disease, while refusal to participate increases it, individual agents have a responsibility to actively engage with socially provided vaccination programmes (and their analogues). By doing so, agents can help to protect their compatriots from major deprivations (Coggon 2012, p.43).

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[1] While the range of scenarios in which agent participation is required for the effectiveness of protection systems is very broad, a common feature of all of them is that the higher the number of people participating in a given social endeavour for the protection of health, the greater the protection it will offer. I noted above that vaccination is more effective for all persons when the number of people participating is higher for example, and the same is true for road safety or considerate smoking behaviour, since in each case the more people who engage with these kinds of collective intervention the lower the risk of harm to third party right holders. Similarly, greater participation in social welfare systems is an effective way to improve their efficacy as demonstrated by the greater effectiveness of publicly funded health care systems compared to private systems (Davis et al. 2014, p.7).

In the following section I provide a brief overview of the way in which the three practical requirements of the duty to protect work together to ensure fulfilment of the duty.

3.5 – The Practical Requirements of the Duty to Protect

In the preceding sections I argued that the types of interventions required by the duty to protect from deprivation as it applies to the basic right to health care can broadly be categorised as falling into three categories. These categories were proposed because collectively they provide right holders with reasonable guarantees of protection against those standard threats which would deprive them of their abilities to enjoy any other rights. I discussed these categories with reference to key examples which illustrate the main responsibilities of duty bearers under the duty to protect from deprivations of health as it applies to infectious disease. In doing so, I provided an outline of the kinds of actions and behaviours required to protect right holders from deprivations caused by infectious disease, and discussed the ways in which these specific requirements can be used to establish principles for the duty to protect from deprivation more generally. These categories of intervention are intended to facilitate fulfilment of the expanded theoretical requirements of the duty outlined in section three of this chapter. The specific interventions discussed in the preceding sections are not intended to represent the full range of specific practical requirements of the duty to protect, since providing such an extensive list would exceed the length of this thesis. However, in examining a limited number of examples it is possible to create a set of general principles which can be used to define the practical requirements of the duty to protect from deprivation as it applies to the basic right to health care.

The three categories of practical intervention of the duty are closely related, with the social infrastructures category being the broadest and arguably the most fundamental. This category of intervention provides the means through which direct medical interventions can be delivered, as well as numerous important social institutions which indirectly contribute to the protection of health. The second intervention category of the duty to protect from deprivation is arguably only slightly less broad than the social infrastructures category, and focuses on the provision of medical services which contribute to the protection of individual health. This requirement demands the provision of goods which are obviously medical, such as the provision of treatment or preventative health care services. It is also more directly concerned with specific individuals than the broader social infrastructures category. Importantly, the delivery of the goods covered by this requirement will depend upon the presence of infrastructure as specified by the previous requirement, meaning that this intervention category requires the effective delivery of those interventions included in the first category. Finally, the participatory-behavioural requirement is focused on the behaviours of individuals and institutions and demands that these agents engage with the services provided by the previous requirements in order to contribute to their efficacy. The participatory-behavioural requirement is essential for the duty to protect from deprivation, since in order for the programmes and interventions covered by the previous requirements to have any effect, they must be funded, and individual agents must actually make use of them.

As noted above, the practical requirements of the duty to protect differ significantly in scope and scale, and as a result, also differ in the agents that will have primary responsibility for fulfilling them. In terms of delivery, the social infrastructures condition will largely be the responsibility of governmental and intergovernmental agents, mainly because of the power enjoyed by such agents. The agents with primary responsibility for the delivery of direct medical interventions are also likely to be governmental or institutional agents, partly because these kinds of agents are more likely to have the power necessary to deliver needed medicines effectively, but also because publicly administered health care systems tend to be more effective, efficient, and accessible than privately administered systems (Schoen et al. 2011; Pritchard & Hickish 2011; Davis et al. 2014). Finally, primary responsibility for the participatory behaviours requirement will lie with both individual and corporate agents, since this requirement focuses on active engagement with the facilities provided by the two prior requirements. The obligations of corporate agents will largely focus on contributing financially to the provision of protective services in order that the practical requirements of the duty may be funded.

It might be objected of the categories of intervention discussed above that they impose obligations on duty bearers which exceed the boundaries of the duty to protect. However, as was argued in sections three and four of this chapter, merely because the duty to protect requires additional duties in the context of the basic right to health care does not render those duties excessive. Indeed, I have argued that for at least some of the practical requirements, effective fulfilment of the obligations they demand will convey significant benefits on duty bearers and reduce health care costs long term.[1] Further, as also argued in sections three and four, and as I discuss again in more detail in the following chapter, these expanded requirements of the duty are compatible with Shue's demand that the guarantees provided by the basic rights are reasonable not 'utopian' (1996, p.32). Therefore, each of the specific interventions discussed above can be provided only to the extent that doing so does not impose excessive costs on duty bearers - I have not argued that the duty to protect from deprivation is not fulfilled unless no-one can ever suffer a deprivation of health. All that is required by the basic right to health care is the provision of reasonable guarantees against standard threats to health (Shue 1996, p.29), a standard with which the requirements suggested in this chapter can readily comply. I discuss this point in more detail in the following chapter when I propose a framework for determining the upper and lower limits of the obligations that can be demanded of duty bearers by the duties to protect from deprivation and to aid the deprived.

In the following section I provide a summary of the argument presented in this chapter, and set out the main themes for the following chapter which discusses the last of Shue's three duties, the duty to aid the deprived.

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[1] I expand upon this claim in the following chapters.

3.6 – Summary

My goal in this chapter has been threefold; first, to discuss the objective of the duty to protect from deprivation. Second, to argue for an expanded interpretation of Shue's description of the duty to protect from deprivation as it applies to the basic right to health care. Finally, to set out the specific responsibilities of duty bearers in terms of three core categories of intervention. In order to do so I focused on the threat of infectious disease, since this is the threat to health which Shue's definition of the duty to protect from deprivation is least able to account. In addition, infectious disease poses a significant threat to all persons, and is one which requires a broad range of responses in order to adequately be addressed.

I have argued that Shue's original statement of the duty to protect can be expanded relatively straightforwardly to account for the threats to health posed by agent independent hazards such as infectious disease. As I argued in section three, this can be achieved with only minor changes to the original statement of the duty. In addition, while expanding the duty to protect from deprivation to account for agent independent threats to health does increase the requirements of the duty, doing so need not exceed the theoretical boundaries of the basic rights model, nor does it impose excessive obligations on duty bearers.[1] Infectious disease is an almost inevitable feature of the lives of all persons, and can cause severe harm which in many cases can be

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[1] In addition, the interpretation of the duty suggested in this chapter is arguably implied by Shue's statement that ignoring deaths caused by malaria is unjustifiable, as noted earlier in the chapter (1996, p.33).

prevented relatively easily. As such, it is plausible to define the threat posed by infectious disease as a 'standard threat' to human welfare (Shue 1996, p.29), and for it thus to qualify for consideration by the basic right to health care and the duty to protect from deprivation. Further, as I have argued, many of the interventions I have discussed in this chapter, such as vaccination and the provision of sanitation and sewerage systems, are cost-effective and help to avoid the need for more expensive treatment services long term, and so should be acknowledged as 'basic' services. Therefore, it is both possible and reasonable to extend the requirements of the duty to protect to apply to those deprivations associated with at least some forms of agent independent hazard.[1]

In the following chapter, I discuss the last of Shue's three duties, the duty to aid the deprived, and provide an outline of the way in which the requirements of this duty may be established, as well as a method of differentiating between competing cases. I do not discuss the duty to aid the deprived with reference to one specific example, since the range of contexts in which aid might be owed is simply too broad. Instead, I discuss a range of cases, and offer a set of five criteria with which to evaluate potential aid scenarios and which can also be used to assign priority for protective services.

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[1] In the following chapter on the duty to aid, I discuss five criteria for evaluating the extent of the duty in different contexts. These criteria (liability, severity, aggregate welfare score, opportunity cost, and ability) are intended to be used to determine when aid is owed and to help differentiate between 'competing' claims on the duty to aid. As I discus in the following chapter, these criteria can also be applied to the duty to protect, and can be used to impose thresholds on the obligations generated by the duty.

CHAPTER FOUR

CONSTRUCTING THE DUTY TO AID THE DEPRIVED

In this chapter I argue for the importance of the duty to aid the deprived as it applies to the basic right to health care. In doing so I propose a framework of five criteria with which to analyse deprivations of health and determine whether aid is owed in any given context. I argue that these criteria can be used to determine whether aid is owed in any given situation, the extent of any aid that is owed, and the agents who are responsible for providing it. I also briefly argue that analysis of these criteria suggests that the provision of aid to the world's poorest people should be prioritised.

In each of the two preceding chapters I discussed the implications of one of the duties in Shue's basic rights model for the basic right to health care. In each chapter I referred to one central example in order to demonstrate the relevance of each duty, and the way in which they apply to the basic right to health care. In doing so, my aim was to support my overall claim that a basic right to health care is compatible with Shue's model of basic rights, and to demonstrate the requirements of each duty as it applies to the basic right to health care. In doing so, I also attempted to show that the basic rights approach provides an effective way of theorising about global health care justice.

In analysing one specific case study in each of these chapters I drew out their key features from which to extrapolate the general requirements of the duty in question. For each of these duties, examples which share common features with other health care and deprivation contexts were used to argue for a general set of principles governing the requirements of each duty. The broad applicability of these examples thereby makes it possible to develop general principles from a small number of cases. In contrast, simple and broadly applicable examples for the duty to aid the deprived are less common. Therefore, in this chapter a broader range of examples is used in order to discuss the broad criteria for the duty to aid the deprived.

In this chapter I provide an outline of five criteria for evaluating potential aid scenarios. These criteria serve four key functions; first, they provide a theoretical framework with which to differentiate between 'competing' cases of deprivation and to enable the just prioritisation of the allocation of resources. Second, they can be used to set priorities for the duty to protect from deprivation, as I discuss in section five. Third, they can be used to establish thresholds of entitlement to aid, and to thus place limits on when, and to what extent, the provision of aid is demanded by justice. Finally, they can be used to assign responsibility for the provision of aid in specific, individual deprivation scenarios, and to determine the extent of the obligations held by different agents.

My focus in suggesting these criteria is not to provide a specific outline of what is required by the duty to aid the deprived; I do not, except in very general terms, state that ‘person X must receive treatment Y in situation Z and those like it’ for example. Rather, the criteria I discuss in section three are intended to provide a means for evaluating deprivation scenarios, ascertaining whether aid of some kind is owed, and discerning the required extent of that aid. In this way, my approach in this chapter echoes that of Daniels and Sabin, whose discussion of methods of priority setting in domestic health contexts proposes a procedural framework with which to evaluate specific health interventions (2008, pp.43–66).

One major difference between the focus of my discussion in this chapter and that of Daniels and Sabin is that while their focus is on resources for health more specifically (since they are concerned with allocating specific treatments or resources for health to specific people), my concern regards the broader, more theoretical question of when, and to what extent the duty to aid the deprived demands action.[1] Importantly, the criteria proposed do not specify the moral justifications for a duty to aid in all cases, since the right to health care alone is sufficient to justify an entitlement to assistance, and corresponding duties to assist, as discussed in chapter one. However, these features are intended to define the boundaries of what aid may be claimed under the right to health care, and which claims may be reasonably rejected.

This chapter is structured as follows; first, I set out the ways in which the duty to aid relates to the pre-emptive duties. Second, I set out three examples

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[1] In addition, the model proposed by Daniels and Sabin focuses more on the procedure of decision making itself, whereas this chapter emphasises the factors which are relevant to such a process of decision making.

of deprivation scenarios in which the duty to aid may be said to engage, and discuss the ways in which the different features of each of these scenarios make establishing boundaries for the requirements of the duty to aid extremely challenging. Third, I propose a set of five criteria with which to evaluate different deprivation scenarios and to establish whether the duty to aid the deprived engages in different cases and what the extent of the obligations it generates might be. Fourth, I provide an overview of the implications of the five criteria, and suggest four general principles which define the practical requirements of the duty to aid the deprived which can be derived from the five criteria. Fifth, I explain how the criteria can be used to set priorities for the duty to protect from deprivation. Finally, I argue that the five criteria provide an argument for the prioritisation of the provision of health care to the most vulnerable people, who are likely to be amongst the poorest people in the world (Pogge 2008c, p.2).

In this chapter I provide an outline of a methodological framework with which to analyse the obligations entailed by the duty to aid the deprived in specific health deprivation scenarios. In doing so I argue for the compatibility of Shue’s duty to aid the deprived with the demands of the basic right to health care, and the importance of the duty to aid the deprived as it relates to this basic right. I start in the following section where I outline Shue’s argument for the importance of the duty to aid the deprived.

4.1 – Aid and the Triumvirate of Duty

In this section I first outline Shue's argument for the importance of the duty to aid the deprived; second, I explain its relationship to the pre-emptive duties; third, I argue for the need to provide a precise theoretical account of its requirements for the right to health care.

First then, Shue argues that the duty to aid the deprived frequently has the 'highest urgency' because it is a duty which is 'often owed to persons who are [currently] suffering' (1996, p.62). As such, failure to provide assistance during times of deprivation, particularly when that deprivation has occurred as a result of failures of the first two duties, will mean that deprived persons 'will have been *totally deprived* of their rights...if they are not then aided either' (italics added) (Shue 1996, p.62).[1] That is, while it is an issue of major concern when the pre-emptive duties are not fulfilled, in such cases there is at least an additional layer of responsibility mandated by the duty to aid the deprived which is intended to provide redress and assistance to right holders. In contrast, should duty bearers fail in their duties to aid the deprived, the consequences are likely to be far worse for right holders because there is nothing after aid that can correct for failures to fulfil the duty (Shue 1980, p.62).

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[1] However, Shue does not take the importance of the duty to aid the deprived to mean that it is always 'more compelling overall' than either of the pre-emptive duties, as I explain below (1996, p.62).

The duty to aid is also distinct from the pre-emptive duties in that its only obvious empirical (as opposed to theoretical) ‘cut-off point’ is death. While all three duties end upon death, the pre-emptive duties also have the occurrence of deprivation as an empirical point of conclusion, since it is analytically impossible to protect someone from a specific deprivation once it has occurred. This may seem a trivial point, but the fact that there is a distinct end point for the pre-emptive duties (even if that end point is beyond the theoretical limits of the duty) means that there is an incontrovertible point at which the demands of the duties cease. As I discuss in more detail below, this is less obvious for the duty to aid.

Secondly, the duty to aid the deprived is not as closely linked to the pre-emptive duties as they are to each other, nor would perfect fulfilment of the pre-emptive duties render the duty to aid the deprived unnecessary.[1] However, the three duties are related, since the extent to which the pre-emptive duties are fulfilled will affect the extent to which the duty to aid the deprived is necessary. Indeed, Shue explicitly argues that failures of the duty to protect can create ‘virtually Sisyphean duties to aid’ (1996, p.63). Conversely, better fulfilment of the pre-emptive duties can reduce the demands of the duty to aid the deprived. The requirements of the duty to aid the deprived are therefore

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[1] As discussed in the previous chapters, the duties to avoid depriving and to protect from deprivation are closely linked, with the latter serving to enforce the former. In addition, Shue argues that perfect compliance with the duty to avoid depriving would render the duty to protect from deprivation ‘unnecessary’ (1996, p.55). Though, as I argued in the previous chapter, this claim does not apply to the duty to protect from deprivation as it applies to the basic right to health care.

partially inversely proportional to the extent that the duties to avoid depriving and to protect from deprivation are fulfilled.

The relationship between fulfilment of the pre-emptive duties and reduced need for the duty to aid the deprived is apparent in the health care context because of the way that effective health promotion and protection measures, such as universal vaccination programmes (Jackson et al. 1993; Colgrove 2006) or public sanitation (Fischer Walker et al. 2013, p.1413), increase the resilience of populations and thereby minimise both the likelihood of harms occurring, and the severity of the harms suffered by individual agents (Sanders & Taira 2003, p.37).[1] It has been noted for example that wealthier people suffer less severe outcomes from natural disasters than poor people because of the resilience enjoyed by the rich due to their access to better social infrastructure (Morrow 1999, p.1; Linnerooth-Bayer et al. 2005, p.1044; Pearce et al. 2010).

However, while effective fulfilment of the pre-emptive duties can reduce the obligations demanded by assistive duties, the number of scenarios in which aid might be beneficial remains large. The existence of numerous threats to health against which there are limited defences at best means that even perfect fulfilment of the pre-emptive duties will not eliminate the necessity of the duty to aid the deprived. To illustrate, infectious disease may cause

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[1] For example, as discussed in the previous chapter, effective vaccination programmes are ‘one of the most successful and cost-effective health interventions ever’ because of the way they remove the need for potentially costly treatments (Expanded Programme on Immunization of the Department of Immunization, Vaccines and Biologicals 2006, p.3).

severe deprivations of health despite universal compliance with the duty to avoid depriving and fulfilment of the duty to protect from deprivation. Further, some deprivations are simply beyond the power of agents to do anything to prevent or avoid, while prevention of others may be practically impossible, or beyond what can be reasonably provided by fulfilment of the pre-emptive duties. Therefore, the duty to aid the deprived is necessary to account for deprivations which were not prevented or avoided by fulfilment of the pre-emptive duties.

Thirdly, the status of the duty to aid the deprived as a ‘last line of defence’ against total deprivation does not, however, mean that aid is owed in all instances of deprivation; like the pre-emptive duties, the requirements of the duty to aid the deprived are ‘realistic, not...utopian’ (Shue 1996, p.33). In some instances of minor deprivation aid is unnecessary, or would provide only a minor benefit to the deprived party. In others, aid may be prohibitively expensive, or have a low probability of success. As such, endorsing an absolute duty to aid the deprived in all circumstances contradicts Shue’s argument that the guarantees provided by the basic rights model need not ‘include the prevention of every imaginable threat’ (1996, p.33).[1] It is

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[1] Another important point, raised by Arras and Fenton, is that excessive focus on health care generally can reduce capacity to fulfil other rights (2009, p.31). This is a more general point about the right to health care, but it demonstrates the importance of acknowledging appropriate theoretical limits to the obligations owed by duty bearers. This point also applies to the relationship between the duty to avoid depriving and the pre-emptive duties, given the relatively higher cost of treatment compared to prevention (Hellinger 1993; Farmer 1999, pp.221–223; Hotez et al. 2009). Since treatment can be so much more expensive than prevention, it is possible that over-reliance on duties to aid would undermine capability to prevent initial deprivations, potentially leading to greater need for the provision of aid to right holders.

therefore necessary to establish principles which define the boundaries of the requirements of the duty to aid the deprived in order to avoid inadvertently imposing excessive obligations on duty bearers.[1] However, as I argue in the following section, the range of examples in which aid is necessary, and in which a duty to aid might plausibly be appropriate makes deriving the extent of the duty to aid the deprived from one example impossible.

In this section I first outlined Shue's argument for the duty to aid the deprived. Second, I explained the relationship between the pre-emptive duties and the duty to aid the deprived as it relates to the basic right to health care and argued for the importance of a duty to aid the deprived. Third, I argued that despite the severity of the consequences of the absence of aid, aid is not owed in all circumstances. Consequently, I argued that it is important to provide a precise theoretical definition of the duty in order to avoid imposing excessive obligation on duty bearers. I discuss this final point in more detail in the following section when I examine three problematic examples for the duty to aid the deprived in the health care context. In doing so, I also examine the difficulty associated with establishing just thresholds for the requirements of the duty to aid the deprived.

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[1] Indeed, Shue argues that the duty to aid the deprived is the aspect of the triumvirate of duty which is most vulnerable to 'complaints that the correlative duties accompanying subsistence rights are too burdensome' (1996, p.63).

4.2 – Three Problematic Examples for the Duty to Aid the Deprived

In the previous section I described the way in which the duty to aid the deprived relates to the pre-emptive duties. In doing so, I argued that it is necessary to provide a precise definition of the extent of the duty in order to avoid inadvertently placing excessive demands on duty bearers. In this section I argue that establishing such precise guidelines is complicated by the range of cases in which aid might be owed, and the complexity of the contexts in which deprivations occur. To do so, I first outline Shue's original statement of the duty to aid the deprived and note that Shue does not provide an explicit statement of the extent of the obligations entailed by the duty. Second, I describe three examples with which to demonstrate the range of scenarios in which aid might be owed, and the complexity of the possible requirements of the duty to aid the deprived in different contexts. Third, I argue that the precise requirements of the duty to aid the deprived are unclear in each of these cases, and that as such it is not possible to derive a general account of the demands of the duty from any one example. Finally, I argue that while the examples cannot be used to establish the boundaries of the duty to aid the deprived directly, certain features of each case are valuable in determining such principles.

First, Shue's original statement of the duty to aid specifies three categories of agent to whom the duty is owed; agents

> '1. Who are one's special responsibility,
>
> 2. Who are victims of social failures in the performance of duties (I), (II-1), (II-2) and,
>
> 3. Who are victims of natural disasters'
>
> (Shue 1996, p.60)

While Shue provides a definition of who must be aided, he says little about what that assistance should be. An initial indication of the extent of the duty may be taken from Shue's claim that the guarantees provided by basic rights be 'realistic, not...utopian' (1996, p.33), but defining what counts as reasonable aid is challenging, and Shue offers no explicit statement of the extent of the duty. A secondary indicator of the possible extent of the duty might be derived from the general purpose of the basic rights in guaranteeing enjoyment of all other rights. This point may suggest that aid must be provided when the enjoyment of other rights is prevented by a deprivation, and to the extent which will enable right holders to enjoy their other rights. However, as I discuss below, this may commit duty bearers to enormous obligations which are potentially impossible to fulfil.

I discuss the difficulty of establishing just limits for the demands of the duty to aid the deprived with reference to three distinct examples; firstly, deprivations where harm is caused by the malicious action of third parties. Secondly, cases of deprivation caused by natural disasters which the pre-emptive duties were powerless to prevent. Thirdly, deprivations not caused by malevolence, or external factors in general, but which are caused by genetic disease or by aging. In discussing these examples, my goal is twofold; first, to demonstrate the range and complexity of contexts in which the duty to aid might be owed, and the variety and breadth of the features of those contexts; second, to demonstrate the need for a comprehensive set of principles with which to evaluate potential aid scenarios.[1]

Firstly, aid might be owed to victims of the malicious or negligent actions of third parties. There are two ways in which deprivations caused by such action can merit attention under the duty to aid the deprived; first, the ‘special responsibilities’ condition of the duty is relevant because liability for harm can reasonably be claimed to establish obligations on the part of the liable party towards her victim (Shue 1996, p.60). Secondly, the ‘social failures’ condition is relevant to this kind of case because of the obligations that states and their citizens have to prevent the occurrence of deprivations – failure to do so thereby generates obligations to aid (Shue 1996, p.60). I consider these examples of obligation generation to be uncontroversial since we do, as a matter of fact, already recognise legal, and moral, claims of compensation and assistance in these circumstances.[2] Indeed, both Thomas Pogge (2008c, pp.18–32) and Sridhar Venkatapuram (2011, p.12) argue that many of our

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[1] I propose a set of such principles later in the chapter.

[2] I discuss this point in more detail below.

obligations to provide aid to the global poor and those suffering from deprivations to their health can be derived from the harms caused to them by the establishment of unjust social institutions by wealthy countries and their citizens.

Establishing the extent of the duty to aid the deprived in contexts such as these may appear relatively straightforward, and can be guided by legal norms of compensation (Freeman 1994). To illustrate, the victim of a car accident might be entitled to compensation from liable parties who may be obliged to provide them with medical assistance which enables the person to function with minimal restriction or difficulty for the duration of the treatment, and pursue their life with minimal reduction in their standard of living once the treatment has concluded. This case may seem fairly obvious, given the direct relationship between the deprived person and the agents who deprived them, our understanding of tort law, and the relatively low costs of providing treatment in such cases.[1]

There are two issues which arise from the example mentioned above; firstly, as discussed in chapters one and three, focusing exclusively on cases of human caused deprivations of health ignores significant sources of deprivation and may seem to suggest that obligations to provide aid arise only out of liability.[2] Further, the conclusions reached about agent caused

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[1] I discuss problems with a liability only approach to duties to aid the deprived in more detail later in the chapter.

[2] There are additional practical issues associated with using liability as a source of obligations to provide aid, such as the fact that establishing liability or guilt takes time,

deprivations of health do not provide an obvious account of the requirement of the duty to aid the deprived as it applies to agent independent deprivations. Secondly, basing duties to aid on liability for the harms caused by a specific deprivation may be taken to imply that what is required by the duty to aid is restoration to the health status enjoyed prior to the deprivation. However, in cases where the agent caused deprivation is extremely severe, restoration to a previously enjoyed status may be impossible, because of the extent of the deprivation, or the limited power of the liable party.

Secondly, the basic right to health care may entitle right holders to aid in cases where the harms in question are independent of agent action, affect more people, and which the pre-emptive duties are powerless to prevent.[1] An obvious example is the occurrence of natural disasters, with which the natural disasters condition of the duty to aid the deprived is concerned (Shue 1996, p.60). Health deprivations caused by natural disasters may include physical trauma (Ahern et al. 2005, pp.36–37; Cook et al. 2008, p.168), infection (Ivers & Ryan 2006; Watson et al. 2007), and psychological harm (Bland et al. 1996; Steinglass & Gerrity 2006). While resiliency against such harms can be improved by effective social policy and the installation of effective preventative measures as discussed in the previous chapter, at least some of the harms caused by natural disasters are independent of agent action.

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may not always be possible, and detracts from our ability to aid immediately, when aid is most needed. I discuss these issues in more detail in section 4.3a.

[1] In this way, this type of deprivation is very different from the previous example.

The potential aid requirements necessary to respond to the second category of deprivations are significantly more complex than those of the first category. There are three main reasons for this complexity; firstly, complexity can be caused by the sheer number of individuals in need.[1] Secondly, and perhaps of even greater significance, is the complexity of treatment required in each individual case. Providing renal dialysis is more complicated, and resource intensive than treating a broken limb for example.[2] Thirdly, natural disasters can destroy or reduce the capacity of infrastructure, making the provision of assistance, and the avoidance of secondary harms (such as disease outbreaks) even more difficult (Watson et al. 2007, p.4).[3]

The potential scale of deprivations caused by natural disasters and the complexity and extended duration of the treatments necessary to respond to them means that the possible demands of the duty to aid in such cases may be extremely demanding, if not outright impossible to fulfil. Further, because

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[1] For example, the Gujarat earthquake in 2001 killed 13,805 people and injured a further 166,000. Additionally, one year after the earthquake 'many thousands still required assistance for paraplegia, poorly healed fractures, amputations, and other mobility problems' (Cook et al. 2008, p.168). Similarly, following an earthquake in Armenia 'the medical needs of 600 cases of acute renal failure—of which at least 225 victims required dialysis—created a second catastrophe described as the 'renal disaster' (Cook et al. 2008, p.168).

[2] Further, and in addition to the immediate harms suffered by victims of natural disasters, Cook at al. note there are also likely to be long term mental health outcomes of natural disasters which are likely to be difficult to treat (2008, pp.171–172). In cases of long term physical impairment, such as renal failure, amputation, or poor recovery from injury, an appropriate response may be to provide palliative care, repeated or improved surgery, or improved prostheses. In cases of psychopathologies, either pharmaceutical or counselling therapy may be appropriate responses to these harms to mental health (Bland et al. 1996; Steinglass & Gerrity 2006).

[3] In addition, assigning responsibility for providing aid is also a more complex task in cases of natural disaster. As noted above, since the harms suffered as a result of the occurrence of natural disasters will generally not be anyone's fault, it is not possible to assign responsibility for the provision of aid based on liability, as it is in instances of the previous category of deprivation.

natural disasters tend to be most harmful to those generally lacking in resources or who are victims of existing social discrimination (Morrow 1999, p.1; Neumayer & Plümper 2007; Stromberg 2007, p.200; Rivera & Miller 2007, p.503), merely responding to the specific harms caused by a given natural disaster may ignore the endemic deprivations which contributed to their initial vulnerability. In such cases, even restoring right holders to their previous health status may leave them below Shue's 'decent life' threshold (or at least, still significantly less well off than their wealthy counterparts).[1] Consequently, an obligation to restore right holders to the health status enjoyed prior to the deprivations caused by a specific natural disaster may be both overly demanding *and* insufficient for justice.

While the two examples above differ in terms of the scope and scale of deprivation, and the complexity of the demands of responding to them, the kinds of harms which occur are similar in both examples. Physical or psychological trauma may occur regardless of whether its cause was the action of one person, or an unpreventable large scale event. Further, in both kinds of case the cause of the harm is external to the person who suffers it, and in at least some of these kinds of case, the harm suffered will be treatable.

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[1] The 'social failures' condition (Shue 1996, p.60) to be relevant here, since it could be argued that those most vulnerable to natural disasters have been made so by failures of the duty to protect. Indeed, as noted above, Pogge (2008c, pp.18–32) and Venkatapuram (2011, p.12) each argue along these lines.

The third category of deprivations of health in which aid may be owed differs greatly from the two previous categories, and includes cases of chronic incurable disease, such as Alzheimer's, Parkinson's or Huntington's disease. In these examples, the cause is almost[1] entirely (in some cases, actually entirely) independent of external factors, all the conditions mentioned are incurable, and all have a profound impact on the affected person's life. In addition, persons with any of these diseases will require increasing assistance as their condition progresses.

These diseases have significant impacts on quality of life, and may, for patients with advanced stages of the disease at least, make enjoyment of other rights and any decent life impossible due to the psychological distress and physical impairment they cause (Schumock 1998, p.s.17; Scheife et al. 2000, p.953; Walker 2007, p.218); Alzheimer's and Huntington's disease can also contribute to death (Walker 2007; N. H. S. Choices 2012; N. H. S. Choices 2013b). Health care responses to the chronic conditions mentioned include limited (and progressively less effective) pharmaceutical management of symptoms (Schumock 1998, p.s.17; Scheife et al. 2000, p.953), and supportive or assistive care (N. H. S. Choices 2013b; N. H. S. Choices 2012).

Like the prior examples, providing aid to victims of these chronic conditions might be extremely costly. Since these cases represent incurable diseases, it is possible that we might be required to indefinitely expend enormous levels

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[1] For example, head injury and exposure to specific environmental hazards can be risk factors for Parkinson's disease (Gorrell et al. 1996, p.652).

of resources to achieve relatively minor quality of life improvements for their victims, thereby reducing the funds available to treat less serious, but more treatable conditions. However, chronic conditions like those mentioned cause significant suffering and can make enjoyment of any rights impossible, meaning that a reasonable guarantee of aid might plausibly be entailed by the basic right to health care. Further, while fully restorative aid is impossible, it is possible to provide assistance which at least ameliorates the more harmful symptoms of these diseases.

In each of these examples, aid is needed by the right holders affected by the particular deprivation hazard. However, providing aid in each case has very different practical requirements, and the agents who are responsible for fulfilling them differ. As such, while aid is certainly *needed* in each case, the extent of any aid owed is unclear. In the first example, aid is likely to only be necessary in the short term, and it may seem reasonable to suggest that the parties responsible for the harms suffered have extra responsibilities to provide aid. However, deprivations of this first type might also reasonably require interventions from those not involved in causing harm, due to failures of the duty to protect, or because of practical considerations, such as the inability of the guilty party to provide aid.[1]

In the second set of cases, aid may be needed in both the short and medium term, and may be more complex due to the number of persons needing aid and the nature of the harms suffered, potentially leading to a very extensive set of

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[1] I discuss this point in more detail in the following sections.

obligations under the duty to aid the deprived. Further, due to the widespread destruction caused by natural disasters the infrastructure needed to effectively respond to these needs may have been severely compromised by the event in question (Watson et al. 2007, p.4). In these kinds of case, the liability argument that enjoys some application to the first category of deprivation scenario is less relevant since no-one is directly at fault. However, the fact that those most vulnerable to harm caused by natural disasters are also often victims of prior social discrimination or disadvantage (Neumayer & Plümper 2007), implies that liability of some sort can be a factor. This point might also indicate that merely restoring them to the health and economic status they enjoyed prior to the occurrence of the natural disaster would be insufficient for justice. As such, the duties owed are more difficult to assign, and it is equally challenging to ascertain the limits of those duties.

Finally, I mentioned chronic, incurable conditions such as Alzheimer's and Parkinson's disease. Unlike the other contexts of care, these conditions represent permanent conditions, rather than acute or transient deprivations of health. As such, the aid that might be required by them is at best palliative or managerial, rather than restorative or compensatory. Further, it is possible that the needs of people affected with these conditions may require extremely high levels of care in order to enable them to enjoy the substances of their basic rights (Shue 1996, p.13). The final category of deprivations also has the potential to commit duty bearers to significant obligations which cannot be grounded in liability. In addition, in at least some cases of these conditions the benefits derived for the patient will be relatively minor compared to the costs of providing treatment.

In the previous section I argued that fulfilment of the duty to aid the deprived is necessary to provide guarantees to right holders that they will be able to enjoy the substances of their rights. I also argued that it is necessary to establish a clear theoretical account of the requirements of the duty to aid the deprived in order to avoid the imposition of excessive obligations on duty bearers. However, as demonstrated by each of the three examples discussed above, it is very difficult to establish just boundaries on duties to aid based on the features of any given example, given the diversity in the features of each of the examples offered.

Liability can be useful in some cases, since it can indicate who should be providing, or paying for aid. However, liability can only extend so far; it does not apply as strongly in the second category of deprivation, or at all in the third category. Further, if the liable agent cannot afford to provide treatment, or if guilt cannot be established, their victim’s right to compensation appears to guarantee very little. Other factors, such as the severity of harm, the need of the victim, or the ability of duty bearers to help might all be useful tools with which to analyse different aid scenarios, but as discussed above, without clear guidelines of the extent of the entitlements guaranteed by the basic right to health care, or of the obligations demanded by the duty to aid the deprived, it is possible for these factors to impose obligations which are themselves impossible to fulfil, or which would make it impossible to fulfil the pre-emptive duties. As such, it is necessary to provide a definition of the extent of the duty to aid the deprived in order to avoid potentially reducing capability to ensure that the basic right to health care actually provides ‘social guarantees against standard threats’ to health (Shue 1996, p.13). However, while individually these evaluative features prove problematic for establishing the boundaries of the duty to aid the deprived, they are nevertheless important and should be considered relevant to the duty.

In the following section I discuss five criteria for evaluating deprivation scenarios in which the duty to aid might be owed. These criteria are suggested as a means of ensuring the best possible use of limited health care resources. They are therefore intended to ensure that the duty to aid is fulfilled thoroughly and efficiently in order to provide as comprehensive guarantee of the basic right to health as possible, though in a way which does not place overly onerous burdens on duty bearers, and allows for comprehensive fulfilment of the pre-emptive duties.

4.3 – Five Criteria for Evaluating Deprivation Scenarios

In the previous sections I argued that the duty to aid the deprived applies to a wide range of scenarios with vastly differing features. As such, it does not appear possible to derive a comprehensive outline of the requirements of the duty from analysis of one specific case study.[1] Further, in the health care

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[1] This is in contrast to the duties to avoid depriving and to protect from deprivation which each apply to a wide range of scenarios from which general principles may be derived, as discussed in earlier chapters.

context the duty to aid the deprived may require potentially infinite duties if appropriate upper boundaries are not adequately theorised. This is due to the fact that in any given deprivation scenario, the definition of which may also be extremely broad, it is likely that *something* can always be done to improve the welfare of the deprived person, even if that action would be extremely costly, and the benefit extremely small or improbable. Such an outcome of inadequate theorising is likely to be impractical, excessively costly, and contrary to Shue's theoretical emphasis on guaranteeing only the minimal standards of entitlement necessary for the enjoyment of other rights. Therefore, it is necessary to provide a theoretical account of the duty to aid which imposes appropriate upper and lower limits on what it requires.

In this section I set out five criteria for evaluating deprivation scenarios in which aid may potentially be owed. The five criteria, liability, severity, aggregate welfare score, contingent ability, and opportunity cost, are all relevant to the evaluation of deprivation scenarios, and can be used collectively to establish the extent of any duty to aid in a given situation, and the agents which are responsible for providing it. In addition, as I argue later in this chapter, they can be used to provide a more general theoretical outline of the requirements of the duty. It is worth noting that the order in which these criteria are discussed does not reflect their relative importance. Rather, I begin my discussion of these criteria with those which offer the most intuitively appealing justifications for a duty to aid, and go on to discuss those criteria which are no less important but which may be less obviously relevant. In this way, I aim to build a comprehensive account of the possible justifications for a duty to aid from the more limited justification possible from the most obvious arguments for the duty. Importantly, my goal in this section, as noted above, is not to offer a set of specific practices or behaviours which are required by the duty to aid. Instead, these criteria are intended to provide a method for determining when assistive behaviour is required by the duty, and to what extent it is required.

4.3a – Criterion One: Liability

In this section I argue that causing harm to other persons, or allowing harm to be caused to them when responsible for preventing it, entails a correlating responsibility to provide aid to the harmed person. Consequently, I argue that liability is one criterion which is relevant to the duty to aid, and is a source of duties to aid in certain contexts. However, this should not be taken to mean that right holders are entitled to aid only when another party is liable, as this would mean that deprivations caused by agent independent factors would not engage the duty to aid the deprived. Rather, liability for deprivations is relevant only as a way of assigning responsibility to specific agents in specific circumstances, rather than as a general justification for the existence of a theoretical duty to aid the deprived.

To argue for the relevance of liability to the duty to aid the deprived I first argue that there are two ways in which agents can be liable for deprivations, and for the cost of providing aid to their victims with reference to two of the sub-conditions of the duty to aid the deprived. Second, I note that while liability provides a valuable way of assigning responsibilities for aiding to specific duty bearers in certain circumstances, it does not justify duties to aid in general, and does not apply in all cases of deprivation. Third, I argue that there are many cases of deprivation in which establishing liability for harms suffered, and adequately responding to that liability would provide sufficient aid to ensure that right holders are not 'totally deprived' of the substances of their rights (Shue 1996, p.62). Finally, I suggest three practical problems for liability as a driver of duties to aid, and suggest a general response to them.

First, liability can be related to both the 'special responsibilities' and 'social failures' conditions of the duty to aid the deprived (Shue 1996, p.60). Firstly, the 'special responsibilities' condition can be interpreted, in a variety of ways, as entailing duties to family members, compatriots, or to members of groups to which one is accountable (as in the relationship between states and their citizens for example). In addition, it can also be interpreted as referring to the relationship that exists between perpetrator and victim, and the compensatory responsibilities owed by the former to the latter; it is widely acknowledged for example that having caused harm to someone puts one in a position of having 'special responsibilities' to them (Calabresi 1975; Cane 1982).[1] This is shown by the existence of prevalent legal norms which entitle right holders to seek compensation from those who have harmed them, as a result of negligence or deliberate action (Dyer 1995; Dyer 1996; Eaton 2010).

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[1] Though as Calabresi notes, the field of tort law scholarship is extremely broad, and not without its own controversies and debates (1975, p.70). For example, defining what counts as liability, or establishing a defence of tort law, are both contentious issues, which would require more analysis than is possible to provide here (Calabresi & Jon T. Hirschoff 1972, pp.1055–1056; Coleman 1987; Coleman 1992, pp.378–379). However, it is reasonable, to state that when a person has caused harm to another, there is intuitive appeal to the claim that they are liable in some way to their victim.

Shue also states that the ‘social failures’ condition of the duty to aid the deprived is a response to the existence of deprivations caused by failures to fulfil the duties to avoid depriving and protect from deprivation (1996, p.57). This condition of the duty to aid the deprived demands that perpetrators of harm, and those who failed in their responsibilities to stop them, have specific duties to provide aid to deprived right holders. As it applies to the basic right to health care, duties to aid derived from liability of this kind might be thought to oblige individual agents to compensate right holders who they have harmed deliberately or negligently. Correlatively, agents with specific protective responsibilities, such as governments, employers, or intergovernmental organisations may have responsibilities to provide aid to those that they failed to protect.[1] In this way, liability as a source of duties to aid the deprived is central to Shue’s statement of the duty, and is compatible with prevalent legal norms of compensation (Coleman 1992; Freeman 1994, p.1456).

Second, while liability for harms suffered is a useful, and intuitively appealing, indicator of the agents to whom responsibility for aiding in specific circumstances, it is not relevant in all cases. As discussed in the previous chapter, the duty to protect from deprivation does not entail an entitlement to an absolute guarantee of protection from all harms. Some

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[1] In a later section I argue for the importance of ability as a measure with which to assign responsibility for aiding deprived persons. Ability is also relevant here however, since it is unreasonable to suggest that an agent can be liable for the harms caused as a result of their failure to prevent them if they were in fact capable of preventing it. That is, agents can only be liable for harms which they had reasonable duties to prevent, if harm was caused by something which exceeds the reasonable bounds of the duty to protect from deprivation, then there is no liability derivable from a failure to protect from it.

sources of deprivation are impossible to control or predict, and others may cause harm despite fulfilment of the duty to protect from deprivation by all relevant parties. Therefore, in cases where there is no duty to protect from deprivation, or where it has been fulfilled but harm has occurred anyway, there is no liability for harm. Shue acknowledges this point in his inclusion of the ‘natural disasters’ condition in the statement of the duty to aid the deprived (1996, p.60). Given the existence of deprivation hazards which duty bearers cannot be liable for, liability does not apply in all cases of deprivations of health. However, as noted above, evaluating the extent of any liabilities for deprivation does provide a valuable method of establishing which agents are responsible for providing aid to deprived right holders in at least some circumstances. Further, as I argue below, liability for failures to protect from deprivation, or for the deliberate imposition of deprivation applies in a wide range of cases.

Third, as argued in chapter two, many existing economic structures are directly harmful to vulnerable right holders, and deprive them of goods to which they are entitled (Oddi 1996; Hubbard & Love 2004; Pogge 2008b). In addition, factors such as poverty, social status, and the inaccessibility of social institutions (Pearce et al. 2010; Yilmaz & Raynaud 2013), all of which are at least partly influenced by the actions of duty bearers (Pogge 2008c, pp.29–30; Venkatapuram 2011, pp.19–20), can also have an appreciable impact on the health of right holders (Wilkinson & Marmot 2003; Clemens & Pettersson 2008; Brock 2009, pp.198–204; Schüklenk et al. 2009, p.404; Wisor 2012). As such, while the failure to fulfil the duty avoid depriving may not be as obvious in cases such as these mentioned as they are in cases of deliberate harm, or failures to protect from such harms, the deprivations caused to right holders can be just as severe.

For example, Amartya Sen has famously argued that famines are an economic or political, rather than natural, phenomenon, which are the result of failures on the part of governments to manage markets in food crops appropriately (1999, pp.162–163).[1] As such, the deprivations caused by famine, which include obvious harms such as death or suffering by starvation, but which can also include the imposition of restrictions on mental and physical development in young children (Brown & Pollitt 1996), and to other secondary health deprivations (Pelletier et al. 1995; Bergstrom & Lindholm 1998), are not the unfortunate consequence of an unpreventable natural disaster. Instead, according to Sen, they are the product of at best negligent regulatory or economic behaviour on the part of agents who, to use Shue's terminology, failed to fulfil their duties to avoid depriving, or to protect from deprivation. As such, liability for the harms caused, and consequently the duties to aid those harmed, can be assigned to those agents who caused, or allowed to be caused the deprivations arising from famines. However, famine is not the only example, economic and health care policy can impoverish vulnerable persons, exclude them from access to goods to which they are entitled and cause significant harm (Pisani 2008, p.192; Pogge 2008a). In

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[1] See also (Bose 2000).

such cases, it is the actions of agents which cause harm, rather than an irresistible natural force.

The wide scope of agent caused deprivations of essential welfare goods means that liability is a relevant consideration in many deprivation contexts. Acknowledging and responding to these liabilities means that it is possible to assign responsibility for providing aid to specific duty bearers in a direct manner in a large number of cases. Indeed, the number of cases in which liability is a factor means that adequately responding to liability as a source of duties to aid the deprived may address a significant proportion of cases of health deprivations suffered by right holders. However, as I discuss below there are at least three practical problems associated with liability as a source of duties to aid the deprived.

Finally, while acknowledging the importance of liability allows the straightforward assignation of duties to aid the deprived in certain contexts, there are at least three practical concerns for the liability criterion. First, in some cases the 'guilty' party will lack the ability, either financial or medical, to provide aid to their victim(s). Second, the guilty party may not be known, and so compensation cannot be claimed from them (unless they admit their responsibility).[1] Finally, in many cases of harm, even those where a perpetrator has the ability to provide financial aid or where they are known,

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[1] We might also note that in some cases the responsible party may have been equally or more severely harmed by their actions and so be incapable of aiding at the time aid was needed. I am thinking here of a car accident caused by one person's negligence, where both individuals were equally harmed and thus in need of aid. In such cases, it also may not be clear who was at fault until after the fact.

such aid may be withheld or responsibility disputed.[1] In such cases, the person in need may require help immediately, and may suffer extremely severe consequences if aid is not provided, but they may not receive aid because of the behaviour of the agent who has caused them to come to harm in the first place.

Collectively these three issues indicate that assigning responsibility for aid purely on the basis of liability, which creates compensatory relationships between offender and victim, is insufficient to guarantee that the duty to aid is actually fulfilled in cases of malicious, negligent, or partial harm. Therefore, some additional structures are necessary in order to ensure that the aid to which right holders are entitled under the right to health care is provided. One immediate possibility is that in all cases where a duty could be owed, aid should be provided by states or delegated public authorities in the first instance, but that where liability is established, the costs, or part thereof, of providing treatment should be recovered from liable parties.[2] In this way, aid may still be 'provided' in a sense by those guilty of causing deprivations, but in an indirect manner, since the costs of provision will be recouped after the needs of vulnerable parties have been met. This indirect approach to the

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[1] These are not theoretical points, but are merely examples of practical problems for the application of liability to the duty to aid the deprived.

[2] This approach can readily be identified with Shue's 'social failures' condition of the duty to aid (1996, p.60), since the initial responsibility to aid resides with the social infrastructures which failed to prevent the harm in question. Importantly however, this approach does leave open the option of recouping costs from liable parties.

provision of aid by liable parties arguably provides a general outline of how to resolve the problems mentioned in the previous paragraph.[1]

I have made four claims in this section; first that liability is relevant to the first two conditions of the duty to aid the deprived, and that it provides an intuitively appealing way of assigning responsibility to specific duty bearers in some deprivation contexts. Second, that liability does not apply in all deprivation contexts, so other criteria are necessary to assign responsibility for aiding, and for measuring the extent of any duties to aid. Third, that while liability does not apply in all cases, it does apply in many, as argued by (amongst others) Pogge (2008c; Wenar 2008), and that therefore, adequately responding to this liability may provide the health care aid which will resolve many deprivations of health. Fourth, I noted three practical issues for liability as a source of duties to aid the deprived, and suggested an outline of a response to these issues. In the following section, I argue for the relevance of the severity of deprivation as a means of prioritising different deprivations.

4.3b – Criterion Two: Severity

In the previous section I argued that examining the liability for harms suffered by right holders is an effective, and intuitively appealing, way of establishing which duty bearers have responsibility for fulfilling duties to aid the deprived. Further, I also argued that while liability will not be a relevant

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[1] This suggestion is not of course a complete answer to the difficulties mentioned. However, to construct an appropriate model which would answer these concerns would require far greater analysis than is possible in a thesis of this length. As such, I shall not pursue this idea and will focus instead on analysis of the other factors which are relevant to the duty to aid the deprived.

factor in all cases, it applies in more cases than may be immediately apparent, because of the significantly harmful consequences of supposedly just economic and social structures. However, analysis of liability provides information only about the agents who owe compensatory duties to aid specific agents whom they have harmed, or allowed to be harmed. As such, it is necessary to examine other criteria when evaluating deprivation scenarios in order to assign responsibility for aid when liability is not a factor, to determine the limits of the duty to aid the deprived, and to provide a means to prioritise different deprivations appropriately.

In this section I examine the first of four additional criteria which I argue are relevant to determining when aid is owed, to what extent, and by whom – severity. In this section I argue that the severity of a deprivation can be used to determine whether aid is owed to its victim, and to establish which cases of deprivation should receive priority when it is not possible to provide aid to all persons who have suffered deprivations of their health. I also argue that severity can be used to define a lower threshold for the duty to aid the deprived. In this way, the severity criterion differs from the liability criterion in that it does not provide an indication of which agents have responsibilities in specific contexts, but instead provides the means to define the limits of the duty to aid the deprived, and to prioritise the allocation of limited assistive health care resources.

To make these arguments I first argue that the purpose of the basic rights is to provide right holders with the goods needed to enable their enjoyment of all other rights, and explain what this means for the duty to aid the deprived as it applies to the basic right to health care. Second, I argue that because more severe deprivations of health typically make it harder for right holders to enjoy their other rights, they should usually receive priority over less severe deprivations. Third, I argue that in some cases the prioritisation of more severe harms is problematic, and may commit duty bearers to unreasonable and inappropriate obligations.

First, as discussed in chapter one, the purpose of the basic rights is to enable right holders to actually enjoy ‘all other rights’ (Shue 1996, p.19). The value of the basic right is therefore derived from their instrumentality rather than the intrinsic value of the goods to which they entitle right holders (Shue 1996, p.20). The basic right to health care is vital to the goal of enabling the ‘actual enjoyment’ of all other rights because of the way in which deprivations of health can make such enjoyment impossible, as also discussed in chapter one (Shue 1996, p.13). Therefore, as it applies to the basic right to health care, the main role of the duty to aid the deprived is to help right holders to recover from deprivations of health which would prevent or limit them from being able to enjoy the substances of their other rights.[1] Doing so is likely to also ameliorate the innately harmful consequences of deprivations

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[1] For example, Gillian Brock (2009, p.66), David Held (1995, pp.192, 194–195) and Martha Nussbaum (2003, pp.41–42) all argue for the importance of physical and mental health for important human functionings. Similarly, Sridhar Venkatapuram has argued that ‘a person’s health is most coherently conceptualized as her ability to be and do things that make up a minimally good, fluorishing and non-humiliating life for a human being in the contemporary world’ (2011, p.20). Therefore, on Venkatapuram’s view, deprivations of health make it more difficult for right holders to achieve important functionings and to live a decent life.

of health, but the goal of the duty to aid the deprived is to enable right holders to regain the ability to enjoy all other rights.[1]

Second, given that the goal of the duty to aid the deprived as it applies to the basic right to health care is to help right holders to recover from deprivations of health which prevent the enjoyment of all other rights, certain deprivations of health can be immediately disqualified from entailing duties to aid. For example, minor deprivations of health which do not impose restrictions on the ability to enjoy other rights, or which impose only minor restrictions do not entail the existence of duties to provide aid to right holders deprived in this way.[2] It is worth noting however, that what counts as a trivial deprivation will vary depending on the general health status of the affected persons; deprivations which would be negligible to healthy and wealthy adults can be fatal to more vulnerable persons (Nazroo 1998, pp.717–718; Morrow 1999, pp.2–3; Haines et al. 2006b, p.592).[3]

Measuring severity in terms of the barriers to the enjoyment of other rights can therefore provide at least a general idea of how to set a lower threshold of the demands of the duty to aid the deprived.[4] However, it can also be used as

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[1] For methodology on measuring the severity of innate harms of health deprivations see for example (Fryback & Keeney 1983; Horn et al. 1983; Horn & Horn 1986; Bion 1990; McKie et al. 1998; Duncan et al. 2006; Skaletzky et al. 2012).

[2] This is perhaps a trivial point, but it is worth noting for purposes of clarity.

[3] I discuss this point in more detail in the following section.

[4] The focus of the severity condition on the impacts of deprivations on the abilities of right holders means that it is similar to the disability adjusted life years (DALY) methodology of evaluating health deprivations (Kothari & Gulati 1997; Lyttkens 2003). However, the severity condition differs from the DALYs approach in that it considers the actual abilities of right holders to enjoy other rights, where DALYs are based on analysis of the 'perceived desirability rather than...activity limitations [of specific disabilities/deprivations]' (Grosse et al. 2009, p.197).

a measure for setting priorities for the allocation of assistive health care resources. As argued above, health deprivations which do not limit the ability of right holders to enjoy other rights do not entail duties to aid because they do not impede the key function of the basic right to health care. From this claim, which is derived from Shue's definition of the basic rights as enablers of all other rights, it is possible to argue that deprivations which are more severe, in the sense that they impose greater barriers to the enjoyment of other rights, or barriers to more rights, should receive priority when allocating assistive health care resources. That is, when faced with 'competing' claims for health care aid, aid should be provided first to the victims of the deprivation which imposes greater barriers to the enjoyment of all other rights. For example, all other things being equal, victims of malaria or tuberculosis should receive treatment before victims of herpes simplex (N. H. S. Choices 2013a) because the latter does not impose barriers to the enjoyment of other rights to nearly the same extent as the former.

This example is arguably obvious, and it is much harder to differentiate cases where the potential outcomes are comparable – it is less straightforward to prioritise between malaria and tuberculosis for example.[1] Another important consideration, noted above, is that the severity of a given deprivation of health may vary according to the relative health, economic, and general welfare status of the affected persons (Eachus et al. 1999; Yilmaz & Raynaud

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[1] However, as I discuss in the following sections, other factors, which are related to severity, can be used to provide a more fine grained method of differentiating and prioritising 'competing' deprivations of health.

2013). As such, the severity measure is in a sense relative, as it is concerned with the outcomes for the specific affected persons. However, while perhaps more complex than it may initially seem, the principle that deprivations which impose greater barriers to the enjoyment of other rights than those which impose lesser barriers is intuitively appealing, and in keeping which Shue's account of the role of the basic rights.[1]

Third, despite the intuitive appeal of the principle that more severe deprivations of health should receive priority over less severe deprivations, this principle may be problematic if applied without consideration of other important factors. To illustrate, in some cases of deprivations of health, enabling enjoyment of any other rights may be medically or practically impossible, and may drastically exceed the cost of achieving the same goal for conditions which are only marginally less severe. That is, enabling patient one to enjoy her rights following a severe deprivation may be dramatically more expensive, or may have far less chance of success than enabling patient two, a victim of a marginally less severe deprivation, to achieve her rights. In such contexts, while one deprivation may be more severe, providing aid to its victim may entail costs which make it impossible to provide aid to many more victims of only marginally less severe deprivations, a potentially troubling result. In this kind of case, the aid needed by the first patient might reasonably be thought to exceed the requirements of duty, given the limited

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[1] Though as I argue in the following section, following this principle without consideration of other factors can lead to intuitively unappealing allocations of resources.

nature of resources, and the numerous other uses to which they could be put for greater overall benefit.[1]

In each of these kinds of case, focusing purely on severity, and taking a 'severity first' view of resource allocation generates obligations to provide aid which may be counter-intuitive.[2] However, in such cases, the remaining three criteria, aggregate welfare score, contingent ability, and opportunity cost, can be used to mitigate this problem and offer the means to provide a more fine-grained analysis of deprivations of health. In the following section, I argue for the importance of analysis of the aggregate welfare score (AWS) of right holders who have suffered health deprivations and are in need of aid.

4.3c – Criterion Three: Aggregate Welfare Score (AWS)

In the previous sections I argued that liability for deprivations can be used to assign responsibility for providing aid in a wide range of cases, and that the severity of deprivations can be used as a way of determining which deprivations should be prioritised for the provision of aid. I also noted that while in general, victims of more severe deprivations should receive priority over victims of less severe deprivations, this can generate troubling conclusions if the principle is followed without consideration of other

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[1] Though as Dworkin notes of the use of QALYs in Oregon, pure aggregation of benefit is not without controversy, as the furore over the decision to prioritise tooth-capping over appendectomies demonstrates (1993, p.887). The unpopularity of the Oregonian experiment with QALY maximisation in public health management (Daniels & Sabin 2008, p.154; Daniels 2008, pp.106–107) suggests that discounting severity excessively can also lead to severe problems. However, in cases similar to that described, this will arguably be less of a concern, given the stipulated similarity in severity of the deprivations.

[2] I noted Arras and Fenton's point about the excessive prioritisation of health care as a human right generally above (2009, p.31).

factors. In this and the following sections, I suggest three additional features of deprivation contexts, which can be used to provide a more detailed analysis of deprivation scenarios, and to thus avoid, or at least minimise, the problems mentioned in the previous section.

In this section I argue that the aggregate welfare score (AWS, or AW score) criterion can be used to differentiate between cases of deprivation in a more precise fashion than the severity criterion alone, and can thus be used to assign priority when the cases being evaluated are similar. I do not in this section attempt to provide a metric for evaluating or measuring AWS, since doing so would require far greater empirical research than is possible for a thesis of this length.[1] Instead, my goal is merely to set out in general terms the importance of factors other than the severity of a given deprivation in isolation from its context.[2]

To make this argument I first define the AWS criterion, and explain how it relates to the severity criterion. Second, I argue that variations in AWS can cause differences in vulnerability to deprivations of health, and can affect the severity of harms suffered as a result of deprivations. Third, I argue that the AWS of right holders affected by deprivations of health should be taken into

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[1] However, inspiration for how such a measure may be developed can be taken from both the quality adjusted life years (QALY), and disability adjusted life years (DALY) approaches to evaluating deprivations of health and ability (McKie et al. 1998; Murray et al. 2013).

[2] This is not intended to suggest that severity is superfluous when evaluating deprivation scenarios, the severity of a given deprivation is central to determining whether aid should be provided to its victims or not. However, as I argue in this section, the severity of a given deprivation is partly dependent on the context in which it occurs, part of which is the general, historical welfare status of its victims. As such, the AWS criterion is a means to provide a more fine grained analysis of the impacts of deprivations, and to enable more just prioritisations of the provision of aid.

consideration, and may lead to different allocation decisions than those based purely on severity. I illustrate this point with some hypothetical examples. Finally, I summarise my argument in this section by explaining how the AWS criterion can be used to differentiate between right holders suffering from superficially similar deprivations of health.

First then, a person's AW score is the measure of their general welfare status over their life to date. It can be thought of as the measure of the cumulative effects of the deprivations and endowments which right holders have experienced. The score is largely historical, and takes into account the general welfare status of persons over time, their ability to enjoy the substances of their rights, and the cumulative impacts of any deprivations which they encounter. While it differs in some important respects from the severity criterion, as I discuss below, the AWS criterion shares a focus with the severity criterion on the ability of right holders to 'actually enjoy the substances' of their rights (Shue 1996, p.13). That is, both criteria measure the extent to which deprivations impose, or have imposed, restrictions on the ability of right holders to enjoy other rights. As a consequence of the general focus of the basic rights model, as discussed in the previous section, both criteria will emphasise prioritising the provision of aid to victims of health deprivation who face the most restrictive and/or widest barriers on their ability to enjoy their rights. However, while the two criteria share a similar focus on the extent of deprivations as barriers to the enjoyment of all other rights, they also differ significantly.

The AWS criterion differs from the severity criterion in three ways; first, unlike severity, it is a feature of right holders, rather than of the deprivation itself. Second, severity as an evaluative criterion of deprivation hazards is predictive and measures the outcome of deprivations; in contrast AWS is largely historical, though with a predictive element as noted above. Third, where the severity criterion measures the harms inflicted by a specific deprivation in isolation from other factors, the AWS criterion takes a broader view, and considers the cumulative impact of a person's unique history when analysing the effects of a given deprivation context. This third feature of the AWS criterion enables analysis of AW scores to differentiate between cases of deprivation in which levels of case specific severity are superficially similar, as I discuss in more detail below. However, I first explain the importance of past deprivations when examining current deprivation scenarios.

Second, AWS is a measure of the general longitudinal welfare status of right holders, and describes the outcomes of the cumulative deprivations and endowments they experience. As it relates to the duty to aid the deprived, the AWS criterion is focused on the extent to which a person's AWS constitutes a barrier to their ability to enjoy the substances of their rights. Like severity, right holders with AW scores which impose greater barriers on their ability to enjoy other rights are likely to receive priority when determining where duties to aid apply.

The aggregate welfare score criterion is proposed as a means to account for two factors which complicate allocation based purely on analysis of the severity of a given deprivation; first, individual deprivation hazards can impose differing restrictions on the ability of right holders to enjoy all other rights depending on their background, even when the level of severity of a given deprivation is superficially similar. For example, lower socioeconomic status is correlated with increased pain and disability caused by hip disease (Eachus et al. 1999, pp.603, 609–611). Similarly, social deprivation, such as low income or inadequate housing have been found to correlate with increased length of hospitalisation even when severity of illness was taken into account (Yilmaz & Raynaud 2013, pp.243, 250–253).[1] Conversely, higher social status, even within relatively well off groups, can have a profound impact on health prospects as demonstrated in Michael Marmot's famous study of British civil servants (1978).

The second aspect of the AWS criterion which is relevant to the evaluation of deprivation scenarios and resource allocation decision making is that variations in AWS mean that victims of specific deprivations rarely start in identical positions of vulnerability and resilience to other persons, meaning that some people are more likely to be deprived of their abilities to enjoy other rights, even if they suffer less severe harms, in a narrow sense, from a deprivation. For example, Paul Farmer, with reference to the disparity of life

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[1] For more on the greater impacts suffered by deprived persons compared to well off persons, see also (Nazroo 1998; Morrow 1999; Karlsen & Nazroo 2002; Wilkinson & Marmot 2003; Siefert et al. 2004; Haines et al. 2006b; World Health Organization 2008; Serpa et al. 2009).

expectancy in rich versus poor nations caused in part by economic deprivation, has argued that ‘North American men with coronary artery heart disease are apt to live much longer than Haitian women with tuberculosis. North American men with coronary artery disease are apt to live longer than Haitian women, period’ (Farmer 1999, p.11).[1] In Farmer’s example, he draws attention to the fact that for many, tuberculosis infection is quiescent or asymptomatic at least initially (N. H. S. Choices 2011), is treatable (Reichman 1997, p.3), and can enable right holders to live long lives, at least in the absence of co-morbidities or contributory factors such as economic deprivation or the inaccessibility of treatment facilities (Rubel & Garro 1992). Despite these points, life expectancy is worse for Haitian women, than it is for American men with the arguably more severe condition. I discuss the implications of this for the allocation of priority for the provision of aid in deprivation scenarios below.

Third, both of the two consequences of AWS variation between persons mentioned above imply that ranking the severity of harms, measured in terms of the restrictions on abilities to enjoy other basic rights, should involve more than analysis of the specific health hazard, since the consequences for different agents can vary. Further, and more importantly, in some cases analysis of the AWS criterion may justify the provision of aid to persons who have suffered an objectively less harmful deprivation at a given time, because of the cumulative impacts of previous deprivations. For example, an instance

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[1] William Ryan has also argued that ‘the facts are plain: their health is bad. The cause is plain: health costs money, and they don’t have money’ (1971, p.170).

of deprivation which, taken in isolation is not especially severe, but when taken as part of a continuum of deprivation can act as a ‘tipping point’ of severity. Beyond this point it can reasonably be suggested that the *collective* severity of a set of ongoing or consecutive deprivations achieves sufficient significance to merit the engagement of the duty. In such cases, a person with a low AWS may suffer a relatively minor (in isolation) deprivation of health, which in conjunction with their already low general welfare, may make it impossible for them to enjoy their other rights. In contrast, a person who enjoys a high AWS is more resilient to deprivation hazards (McMichael et al. 1996, pp.8, 61, 125; Pelling 2003, p.3), and can endure more severe (in isolated terms) deprivations of health before they are rendered unable to enjoy the substances of their rights.

I argued above that the purpose of the basic rights is to enable right holders to enjoy all their other rights, and that as such the goal of the duty to aid the deprived is to help right holders recover from deprivations which prevent such enjoyment. Therefore, the appropriate way of determining which right holders should receive priority in the allocation of aid is not to measure the severity of the deprivations that they suffered in isolation. Instead, while severity of a deprivation is important, it should be considered in terms of the AWS of affected agents following a given deprivation. This is because, as noted above, agents with lower AWS can be left far worse off than their more fortunate counterparts when affected by deprivations of the same, or even lesser severity.

To illustrate, taking a score of 1 as perfect health and well-being, and a score of 0 to mean death, a score of 0.5 can be stipulated to represent the level at which it is possible to enjoy other rights. For two agents, Tony and Cleo, living at this threshold, suffering identical deprivation events which imposed a penalty in absolute terms of 0.4, would result in their AWS scores falling to 0.1. In an alternative scenario where Cleo is assumed to be a citizen of a country which provides significant health promotion services, and starts at a higher score of 0.7, the outcomes for the two agents will be different. When the same absolute harm is done, both Tony and Cleo ‘lose’ 0.4, but the post-deprivation event score for Cleo is higher at 0.3, than it is for Tony who falls to 0.1. As such, Cleo remains better off than Tony throughout the scenario. This is compounded by the fact that as a result of her higher starting position, Cleo is likely to enjoy significantly greater resilience than Tony, and is less likely to suffer harms which are as severe, as argued above.[1] That is, while one event may have an impact of -0.4 on Tony, the same event might plausibly only have an impact on Cleo of -0.2 because of the services which she enjoys.

A third person, Jules, might also plausibly be added to the above example. Unlike Cleo or Tony, Jules is one of the 2,533 million people around the world living in severe poverty (Pogge 2008c, p.211), meaning that she lives on $2 per day or less. It can therefore safely be assumed that Jules does not enjoy an aggregate welfare score of 0.5. However, for the sake of the

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[1] See for example (Neumayer & Plümper 2007; Callaghan et al. 2007; Kahn 2005).

example, it can also be stipulated that she is not entirely deprived and that she has a score of 0.3. In this scenario if Jules were to experience an equivalent deprivation to that experienced by Tony and Cleo she would end up with a score of below zero, which was previously specified as equating to death.[1] However, even if Jules suffers a health impact which is lesser in absolute terms than that suffered by Cleo and Tony, of -0.3, she would still end up worse off than either of her fellows.[2]

It is also relevant that Jules started out in a worse position than either Tony or Cleo (indeed, she started in a much worse position than Cleo under the second iteration of the starting points) since, in living below the decent life threshold, she has experienced a greater level of deprivation than either Tony or Cleo. As such, there is reason to think that the liability criterion may also apply in such contexts, since harms she suffers may be partially the result of the past failure of duty bearers to provide her with adequate protection. Arguably, this, combined with the more deprived starting position Jules begins from, gives extra reason to prioritise providing Jules with treatment instead of Cleo or Tony.

These hypothetical examples, and the real examples suggested earlier in the section provide good reason for taking factors other than the isolated severity

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[1] It may well be possible that negative scores may be possible for those who are still alive in cases of extreme chronic pain, but for the sake of simplicity I will stipulate that the deprivation in this example kills Jules outright once her score reaches zero.

[2] Further, since people starting in more vulnerable positions are, as a matter of fact (Farmer 1999, p.11; Morrow 1999; Linnerooth-Bayer et al. 2005; Haines et al. 2006a; Neumayer & Plümper 2007), more at risk of deprivation events and are likely to suffer worse outcomes from them, it is probable that the event which inflicted harm on Jules may have far less severe consequences for either Cleo or Tony.

of a specific deprivation into consideration when evaluating deprivation scenarios. For example, in some cases it may be appropriate to provide aid to persons who have suffered less severe deprivations in the current specific instance because their low AWS means that they may be worse off following the deprivation than their counterpart who suffered a ‘worse’ deprivation. Analysis of right holder’s AW scores can also serve to differentiate cases where two (or more) right holders suffer equally severe deprivations, as in the case of Cleo 0.7 and Tony 0.5. In this example, both persons suffer the same level of deprivation, but their starting positions mean that Tony is left worse off overall. Since it was stipulated that a score of 0.5 represented the level at which it is possible to enjoy any rights, in this example Tony faces greater restrictions on his abilities to enjoy his rights than Cleo does, so appears to be a better candidate for having his needs prioritised. Though, as I noted above, and discuss in the following sections, greater barriers to the enjoyment of rights may not always provide justification for victims of a given deprivation to receive prioritised aid.

The AWS criterion is suggested as a means to provide more detailed analysis of deprivation scenarios than severity alone. The criterion is not intended to supplant severity, since in some cases the severity alone of deprivations suffered by different agents will be enough to determine which should receive prioritised aid. However, in some cases, measuring the severity of a given health deprivation in isolation from other contexts will ignore the actual ability of affected right holders to enjoy the substances of their rights. In such cases, AWS can be used as a ‘tie-breaker’ or as a means of assigning priority to those who are in fact worse off, but who would be overlooked by resource allocation decision making based purely on the severity of a given deprivation. However, while the AWS criterion provides valuable analytical precision when considered with the severity criterion, it is not able to provide an account for the kinds of case mentioned briefly in the previous section, in which excessive severity, and the correlative cost of providing aid that it entails, may actually impose unreasonable demands on duty bearers, and exceed the demands of the duty to aid the deprived. In the following two sections I suggest two additional features which I argue can impose justifiable upper limits on the duty to aid the deprived, and help to assign responsibility for aiding to appropriate right holders.

4.3d – Criterion Four: Contingent Ability

The criteria I suggest in the previous sections are intended to provide the analytical tools with which to assess deprivation scenarios and determine three things; first, which agents are responsible for providing aid in a given deprivation scenario. Second, whether aid is owed, and third, which deprived right holders should be prioritised when making allocation decisions. While these criteria provide valuable guidance about a wide range of deprivation contexts, they raise two concerns; first, liability does not apply in all cases, and thus cannot guide the assignation of responsibility to aid outside of certain contexts.[1] Second, the severity and AWS criteria provide a lower

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[1] There are also a number of practical problems associated with the liability criterion as noted above.

threshold for the duty to aid the deprived, and enable differentiation and prioritisation of deprived right holders, but do not provide a sound theoretical definition of an upper threshold to the duty.

In this section, I propose the first of two final criteria for the evaluation of deprivation scenarios which together address these issues. I first, in this section, argue that analysis of the ability of right holders in light of certain important criteria can be used to determine appropriate upper limits on the extent of individual duties to contribute to the provision of aid, and can establish which agents should be assigned such duties in specific contexts.[1] To achieve this goal, I first suggest three problems associated with an overly simplistic interpretation of ability, and argue that consequently the appropriate term should be ‘contingent ability’. Second, I demonstrate how this criterion can be used to define appropriate upper boundaries on individual duties to aid the deprived. Third, I argue that evaluating the ability of different duty bearers can indicate which agents should be assigned responsibility for the provision of aid in different contexts.

First then, while the brute ability of duty bearers is of significance to their duties to aid the deprived,[2] their ability alone should not be taken to justify an obligation to provide aid. There are three reasons for this; firstly, in many cases it may be possible for duty bearers to provide aid but doing so may impose excessive costs on duty bearers, which make it impossible to provide

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[1] In the following section I discuss the question of the extent of the duty to aid the deprived in general.

[2] Since one cannot have duties to do what one is incapable of doing.

other important services or for them to enjoy other basic rights (Nickel 1993, p.83; Barrett et al. 2006, p.1118; Fleck 2006, p.13).[1] Related to this point is the levelling down, or ‘jeopardy’, objection which criticises duties to aid based on ability on the grounds that they would require well off right holders to sacrifice enormously until they were no better off than those they helped (a general welfare/economic status of ‘Pareto optimality’ (Sen 1999, p.117)) – thus causing great harm to the duty bearer (Rorty 1996, pp.10, 14–15) cited in (Pogge 2008c, pp.7–9).[2]

The second consideration is closely related to this first point, in that in some cases, while ability to provide aid may exist, it may not be needed by the persons who suffer deprivation. This may be either because the deprivation is mild, and does not impose any significant barrier on the ability to enjoy the substances of rights, or because the victim enjoys significant welfare and resource advantages that enable them to acquire the aid they need without additional support from third parties.[3] Thirdly, while it may be possible to derive generally held duties to aid based on the ability of duty bearers to provide it, in specific circumstances, there may be certain right holders who are best suited to fulfilling the duty (Nickel 1993, pp.80–82). As such, duty bearers may have their responsibilities waived in certain contexts where

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[1] I discuss this point in more detail in the following section, where I argue for the importance of analysis of opportunity cost when evaluating deprivation scenarios as potential sources of the duty to aid the deprived.

[2] Pogge does of course reject the force of the jeopardy argument (the claim that in order to help the poor and vulnerable, the wealthy would have to suffer such a great loss in their own welfare that it would be unreasonable to ask it of them).

[3] I discussed these points in more detail in the sections on the severity and AWS criteria.

others are more able or better suited to fulfilling the duty.[1] In addition, as discussed above, liability for harms suffered may impose prior duties on liable parties which render duties based on ability superfluous.

Secondly, while it is reasonable to be hesitant to endorse a principle which would create obligations purely from the ability to fulfil them, the ability to provide assistance to people in need remains relevant to evaluating the requirements of the duty to aid the deprived in particular deprivation scenarios. Therefore, I suggest that when assessing deprivation scenarios it is reasonable to consider the ability of duty bearers when determining the extent of any duties to aid which apply, and when identifying the duty bearers to whom responsibility should be assigned. However, ability should be considered in light of the costs of aiding incurred by duty bearers in order to ensure that the duties owed are reasonable, and assigned to the most appropriate agents. Therefore, the appropriate term for the criterion discussed in this section is the *contingent* ability criterion. In the rest of this section I argue for the utility of this measure as a means of establishing upper limits to individual duties to aid the deprived, and for assigning responsibility for fulfilling the duty.[2]

The three issues noted above mean that brute ability is inappropriate as a source of duties to aid the deprived. However, having the ability to aid does

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[1] However, they may have duties to support the delivery of aid indirectly, as I discuss below.

[2] In the following section I discuss the final criterion, opportunity cost, which I argue can be used to prioritise the treatments which should be provided through agent ability in a similar manner to the way in which the AWS criterion can be used to refine judgements about priority setting made using the severity criterion.

generate some justification for providing it; at least if doing so would not demand excessive sacrifices from the aiding party. This is a claim made by both T. M. Scanlon (2000, pp.224–228) and Peter Singer (1972, p.231), who both endorse duties to aid based on ability as long as the costs to duty bearers, are not excessive.[1] Correlatively, Anita Ho has argued that the significant power of pharmaceutical companies, their relationship to victims of the HIV/AIDS epidemic in Africa, and the relatively low cost of providing aid, means that pharmaceutical companies have duties to aid victims of the HIV/AIDS epidemic in Africa (2005, pp.52, 59–60, 75).

For Ho, Scanlon, and Singer, the upper limits of the duties to aid the deprived held by specific duty bearers are derived from their capability to provide aid in absolute terms (their brute ability), mitigated by the costs which providing aid to others would impose. Therefore, according to these theorists while duty bearers may have the brute ability to provide aid, they are obliged to do so only to a reasonable extent. To illustrate, in the example provided by Ho pharmaceutical companies are claimed to have duties to aid victims of the HIV/AIDS epidemic in Africa because they have the ability to produce antiretroviral medicines, and provide them free of charge to victims of the epidemic without incurring excessive costs (2005, p.64). In this case, the obligation to provide free medicines extends only to a very small percentage

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[1] Scanlon also notes that the extent of previous contributions to the provision of aid should be taken into consideration when assigning duties, in order to avoid demanding ‘unlimited sacrifice if it is divided into small enough increments’ (2000, p.224). Similarly, Nickel has argued that any duties to aid based on ability must consider the long term sustainability of those duties, in order to avoid committing duty bearers to obligations which would become excessive long term (1993, p.81).

of potential customers of the pharmaceutical industry who are in extreme need. There is not an obligation on the part of pharmaceutical companies to provide free medicines to all persons, and Ho emphasises the rights of pharmaceutical companies to profit from the sale of medicines in other contexts, though not to do so at the expense of extremely vulnerable people in severe need (2005, pp.64–66). Therefore, according to Ho, this duty on the part of producers of antiretroviral medicines is reasonable and, in terms of the criterion discussed in this section, within the threshold determined by the contingent ability criterion.

The purpose of an upper limit on the duty to aid the deprived is to avoid the imposition of duties to provide aid which, though possible to fulfil in absolute terms (meaning that there exists brute capability to provide aid), would entail unreasonable costs to those tasked with delivering aid. While it is not possible to provide a precise definition of ‘reasonable costs’ here, it is possible to derive a general outline of what would count as a reasonable cost from the arguments of the theorists noted above. Reasonable costs are firstly, those which do not require duty bearers to sacrifice ‘anything of comparable moral importance’ (Singer 1972, p.231). Secondly, and as a consequence of the first point, they are relative both to the needs of the deprived, and the resources of duty bearers (Ho 2005, pp.52, 64–66, 72). Third, they must be sustainable, acknowledge prior contributions, and avoid preventing the provision of other important goods (Nickel 1993, p.81; Scanlon 2000, p.224; Arras & Fenton 2009, p.31). Following this definition it can be argued that duty bearers who have fulfilled their duties to avoid depriving and protect from deprivation,[1] cannot be allocated duties to aid which would severely impact their own welfare.

This condition may seem to limit the utility of the aid that can be provided by the duty so much as to fail to meet the goals of the basic rights model. However, Shue describes as ‘absurd’ the claim that ‘everyone has a basic right not to be allowed to die or to be seriously ill’ (1996, p.25). He also states that the ‘measure [of what is required by the basic rights model] is a realistic, not a utopian one’ (1996, p.33). As such, the demands of the basic rights model do not include guarantees of aid in all circumstances. In addition, it has been argued that it is possible to achieve significant improvements in welfare, and deliver effective aid to the deprived at relatively little cost, suggesting that the duties owed by duty bearers need not be excessive in order to provide significant help to the deprived (Dasgupta 1993, pp.92–93; Pogge 2008c, pp.9–11; Hotez et al. 2009). Further, as discussed in section 4.3a, many deprivations of health are the result of the failures of agents to fulfil their duties to avoid depriving or to protect from deprivation. Therefore, in many cases where aid is needed the cost of providing it will be met by liable parties upon whom more stringent demands may reasonably be placed. Consequently, while the duties derived from the contingent ability of duty bearers is limited by what can reasonably be

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[1] This condition is important because, as argued in section 4.3a, it is reasonable to impose additional duties on those liable for causing or failing to prevent deprivations of health.

demanded of them, this does not mean that general capabilities to aid will be unable to respond to deprivations caused by standard threats to health.[1]

Thirdly, measuring the contingent ability of right holders provides one means of establishing an upper limit on the duties which can be owed by specific duty bearers. It can also be used to determine which duty bearers should have responsibilities for fulfilling the duty to aid the deprived in different contexts. To do so, it is first necessary to acknowledge that different types of agent have different levels of ability, and that ability to aid can also vary within types. For example, governments are likely to have significantly greater power to provide aid than individual citizens for example, and governments of wealthy countries are likely to have greater abilities than governments of poorer countries.[2] Further, multinational corporations are also likely to enjoy greater abilities than individuals, and arguably less than governments (in most cases at least) (Jackson 1993, p.549).

By analysing the different levels of ability held by different agents, the contingent ability criterion can be used in conjunction with the liability criterion to assign responsibility for providing aid to specific agents, and to develop structures to guarantee fulfilment of the duty to aid. For example, in

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[1] As I argue in the following chapter, there are also significant economic advantages to be gained from providing health care to vulnerable persons, meaning that the cost of providing aid is offset by the benefits associated with living in a healthy population (UNAIDS 2003).

[2] It might also be noted of more powerful agents generally, that the mere existence of ability to act may in fact generate at least some obligations of justice to provide aid to the needy, or at least to serve as extra justification for more extensive duties generally. This claim of ‘can implying should’ has been discussed by Venkatapuram (2011, p.21), when he analyses Amartya Sen’s argument for the claim (1988, p.273; 2010, pp.205–207).

the case of widespread, severe harms, or where harms occur internationally, the appropriate agents to respond will usually be national governments, due to the ability of such agencies to respond to harms on wider scales. Nickel has referred to this role of governmental agents as being that of the 'primary addressee' of duties to provide essential goods (Nickel 1993, pp.80–81).[1] Correlatively, he describes individual and corporate agents, and intergovernmental organisations as being 'secondary addressees' of this kind of duty (Nickel 1993, p.81). Nickel argues that the role of secondary addressees remains significant yet will be indirect and focus on financial and behavioural support of the actions of international actors such as governments (1993, p.81). In this way, the role of individual agents in the context of the global duty to aid will be very similar to that of agents under the global duty to protect,[2] and will largely consist of contributing to the financial cost, through taxation, of the provision of aid to those in need. In addition, he argues that intergovernmental agents such as the United Nations and the World Bank have duties to support the efforts of national governments to protect and provide rights (1993, p.83).

In this section my goal has been to show how evaluation of agent ability can be used to help determine the agents to whom responsibility should be allocated, and the extent of the duties owed by these specific agents.

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[1] Nickel's argument for the assignation for responsibilities relating to the protection and provision of rights is highly applicable to the assignation of specific responsibilities correlating to the duty to aid the deprived. It is based on the relative capabilities and authorities of different types of agents, and thus provides a framework which can be adopted to work with the contingent ability criterion.

[2] As discussed in the previous chapter.

Importantly, I have argued that while ability *qua* ability is important, other factors must be acknowledged when considering potential aid scenarios. As such, the criterion refers to contingent ability, rather than brute ability. Collectively, the factors which may limit the obligations owed as a result of the ability to provide aid can be described as the opportunity costs of providing aid. This term refers to the impact that performing one set of actions as a result of the duty to aid will have on other relevant agents. In the following section I discuss opportunity cost in more detail, and set out the ways in which appropriate analysis of the opportunity costs associated with different actions is an essential aspect of determining the requirements of the duty to aid.

4.3e – Criterion Five: Opportunity Cost

In the previous sections I have proposed four criteria with which to determine the requirements of the duty to aid the deprived in specific deprivation scenarios. In this section I propose a fifth and final criterion which I argue can be used to provide even more detailed analysis of different deprivation scenarios, and importantly the aid strategies which respond to them.[1] In this section I argue that this fifth criterion, opportunity cost, can be used to compare and prioritise alternative aid strategies in health deprivation contexts in which the four criteria are instantiated roughly equally. That is, in

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[1] I use the term aid strategy to refer to the possible alternative allocations of resources to specific persons which are possible in any given allocation scenario. For example, in a case where either person A could be treated with medicine 1, or person B could be treated with medicine 2, two distinct aid strategies are possible, A1 or B2.

situations in which the alternative deprivations are roughly equal in terms of liability, severity, AWS, and contingent ability. In addition, I argue that this criterion can be used to help define the upper threshold of the general duty to aid the deprived. To make this argument I first define opportunity cost, and explain its importance for the duty to aid the deprived. Second, I set out how the criterion can be used to prioritise alternative aid strategies in deprivation scenarios in which the other criteria are equally present. Finally, I argue that the opportunity cost criterion can help to define the general upper threshold of the requirements of the duty to aid the deprived.

First then, opportunity cost has been defined as the ‘[b]enefits foregone by particular use of resources’ (Palmer & Raftery 1999, p.1552). As it relates to the duty to aid the deprived in the health care context, these foregone benefits include; first, the aid denied to those who do not receive treatment as a result of a decision to provide it to others (Barrett et al. 2006, pp.118–119). Second, and related to the first type of opportunity cost, the protection denied to groups who are indirectly affected by the decision to provide aid to one group instead of another.[1] Third, the goods which duty bearers are unable to acquire or enjoy for themselves, as a result of their contribution of resources to the provision of aid to right holders.[2] Fourth, the protections and advantages of non-health related goods, the provision of which is precluded by the cost of providing aid to victims of deprivation.

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[1] Such costs may be incurred as a result of the spread of infectious disease from an untreated group to associated groups (Battin et al. 2009, p.34), and is related to the discussion of treating to protect as discussed in the previous chapter.

[2] This is the kind of opportunity cost associated with the contingent ability criterion as discussed in the previous section.

Each of these aspects of the opportunity costs of different aid strategies is relevant to the process of resource allocation decision making because the finite nature of resources means that the decision to allocate resources to a given aid strategy may preclude the provision of other, potentially important, goods to right holders. While aiding those deprived of their health is vitally important, as argued above, there are a range of other goods which are also vital to the enjoyment of a decent life, most importantly the other basic rights, and which must also be guaranteed to right holders. Given the finite nature of resources it is therefore necessary to analyse the opportunity costs of different aid strategies in order to avoid undermining capability to provide all right holders with reasonable guarantees of the ability to actually enjoy the substances of their other basic rights. In the rest of this section I set out how analysis of opportunity cost can be used to choose between competing aid strategies, and to help define upper limits on the duty to aid the deprived.

Second, in some cases of deprivation, analysis of the four criteria mentioned in the previous sections may not provide a clear indication of which deprivations should be prioritised. In such cases, where two or more cases of deprivation are similar in terms of liability, severity, AWS, and contingent ability, I argue that the opportunity cost of providing aid to one deprived person or another can indicate which persons should be aided. For illustrative purposes I focus on one example to demonstrate how opportunity cost can be used to choose between deprivation scenarios where the other four criteria do not provide a clear indication of which deprivations should be prioritised

The approval of the cancer medication 'Trastuzumab' (Herceptin) for use in the British National Health Service (NHS) was highly controversial because it is less cost effective than alternative therapies (Barrett et al. 2006, p.1118; Dyer 2006), and carries greater risk of major adverse side effects than existing cancer medicines (National Institute for Health and Care Excellence 2006, p.4). Therefore, Barrett et al. argued that 'the real cost of Herceptin is in the other patients not treated' (2006, p.1119).[1] In this case, opportunity cost is represented by the benefits foregone by those who will be denied treatment because of the decision to prioritise the needs of others. For example, Barrett et al. state that the cost to the NHS trust which they represent of providing Herceptin to the 75 eligible patients in their care would be £2.3 million (US$3.6 million), significantly greater than the cost of providing alternative treatment to the 355 other cancer patients being treated by the Trust (2006, pp.1118–1119). In this case, an aid strategy which emphasised the provision of Herceptin to eligible patients was argued to be

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[1] Another context in which the varying opportunity costs of alternative aid strategies are relevant was examined in the previous chapter. In discussing the requirements of the duty to protect from deprivation I considered the importance of providing treatment to groups affected with infectious disease in order to protect currently unaffected groups. In such cases, the opportunity cost of providing treatment to one of two needy groups includes both the cost to the non-chosen group, but also to those who will be disadvantaged indirectly, through transmission of disease from the initially disadvantaged group. In this case, calculating the total opportunity cost of any allocation must account for the costs imposed on all three groups, and not just those which are immediately affected. In such cases, I argued that the greater harms, or opportunity costs, suffered as a result of treating the isolated, as opposed to infectious, group, motivated aiding the group that was likely to pass on infection. In addition, as also discussed in the previous chapter, failures to adequately control infectious disease can contribute to the evolution of antimicrobial resistance, the consequences of which should also be considered as part of the opportunity cost of poor resource allocation decision making (Farmer 1999, p.247; Ormerod 2005, p.17; Faustini et al. 2006, p.158).

unjustifiable on the grounds that the opportunity costs of doing so are far higher than at least one alternative.

In this case, each aid strategy, to provide Herceptin to those who need it, or alternatives to those who do not, is roughly equal in terms of the first four criteria proposed in this chapter. First, there are no parties who are liable for the deprivations suffered by either set of patients, so liability cannot indicate a greater obligation to one group instead of another. Secondly, the severity of the possible harms suffered can be thought to be comparable, as can the AWS of the affected persons because the outcomes for those not treated will be fatal, and all were patients of the same NHS Trust. Third, the contingent ability of the health service to provide either Herceptin to one group, or alternatives to another group, does differ, since Herceptin is the more expensive option. However, it might be argued that the cost of Herceptin is not *in itself* prohibitive. That is, the cost of providing Herceptin to those who would benefit from it would not be an unreasonable burden on duty bearers, taken in isolation from other considerations.

What differentiates the two aid strategies in the example, are the opportunity costs associated with each option. Providing Herceptin would prevent the provision of equally important medicines to a larger number of right holders in equal need. Therefore, while the other criteria do not obviously indicate a preference for either strategy, analysis of the opportunity costs, in terms of the benefits foregone by the decision to pursue either aid strategy, indicate that the provision of Herceptin is unjustifiable. This is because more patients could be treated if Herceptin was not offered, at a lower cost and for outcomes which were at least as good for those treated. As such, the opportunity costs of the Herceptin aid strategy are significantly greater than that of the alternative strategy.

By drawing attention to the ‘benefits foregone’ by the two options in the above example, the opportunity cost criterion highlights factors which are not considered by the other evaluative criteria (Palmer & Raftery 1999, p.1552). By doing so, it enables more finely grained analysis of scenarios in which aid is needed, and provides a means to differentiate between superficially similar cases. Consequently, analysis of the opportunity costs associated with any given aid strategy can help to determine where aid should be allocated, and which cases of deprivations should receive prioritised treatment.

The third claim I make in this section is that the opportunity cost criterion can also be used to help define an upper limit to the requirements of the duty to aid the deprived. Providing aid of any kind carries opportunity costs because the resources available to provide aid and other important goods, health-related or otherwise, are finite. This means that the allocation of resources to the provision of aid reduces the resources available to guarantee other goods, including the other basic rights. In some deprivation contexts aid strategies may be available which generate relatively minor opportunity costs, and which do not prevent the enjoyment of other basic rights. The non-Herceptin aid strategy in the example above is such a kind of case. In contrast, there may be deprivation scenarios in which all available aid strategies carry significant opportunity costs, which would make the enjoyment of other basic rights impossible. That is, it may be possible to provide aid, but doing so would preclude the provision of other important goods because of the high costs of doing so.

Opportunity costs in the form of foregone basic rights are particularly important because, as discussed in chapters one and two, the interdependence of the basic rights means that they must all be guaranteed if any are to be enjoyed (Shue 1996, p.19). If the provision of health care aid is prioritised to the extent that the other basic rights are not guaranteed, then the basic right to health care has been fatally undermined, as argued in chapter one.[1] Therefore, it is necessary to ensure that the demands of the duty to aid the deprived as it applies to the basic right to health care are limited at least to the extent that fulfilment of the duty avoids making it impossible to guarantee the other basic rights. This may mean that the duty to aid the deprived as it applies to the basic right to health care may in certain cases not require the provision of aid to deprived persons when providing aid would eliminate capacity to provide other basic rights.[2] In such cases, providing aid may be valuable for the person(s) aided, but may impose major opportunity costs on other right holders in terms of other basic rights foregone.

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[1] I made a similar argument in chapter two, when I argued that the right to monopoly control of intellectual property cannot be absolute, even if it is a basic right, because such a guarantee would undermine the basic right to health care, and thus all other rights, and itself.

[2] For example, the British National Institute for Health and Care Excellence stipulates that treatments which cost more than £20,000 per QALY gained are not cost-effective and suggest that advisory panels take this measure of cost effectiveness into consideration when making recommendations about particular therapies (National Institute for Health and Care Excellence 2012, p.116).

Providing an exact account of how to measure the opportunity costs of different aid strategies, and determining exactly how to balance the provision of health care aid with the requirements of other rights is beyond the scope of this thesis. However, in general terms it can be stated that the duty to aid the deprived cannot entail duties, the fulfilment of which would make it impossible to guarantee at least the other basic rights. The upper boundary of the duty to aid the deprived as it applies to the basic right to health care can therefore be defined in terms of the compatibility of any given aid strategy with the provision of concurrent guarantees of at least all the other basic rights.

In this section I have argued that the opportunity cost criterion can be used to determine which aid strategies should be adopted, and that, other factors being equal, priority should be given to those strategies with lower opportunity costs. I have also argued that the criterion can be used to establish an upper limit on the requirements of the duty to aid the deprived. However, like the other criteria proposed in this chapter, opportunity cost is not intended to function alone, and it must be considered in light of the other criteria. In the following section I discuss the ways in which the five criteria set out in these sections might be applied to a range of deprivation scenarios, and thus enable the development, over time, of a comprehensive picture of the general requirements of the duty to aid.

4.4 – Overview: Setting Priorities and Defining the General Principles of the Duty to Aid Using the Five Criteria

In this section I first summarise the arguments presented in the previous sections and offer an overview of the way in which the criteria can be used together to determine the requirements of the duty to aid the deprived.[1] Second, I outline the general principles which can be derived from the five criteria which define the requirements of the duty to aid the deprived.

Firstly, at the beginning of this chapter I argued that the role of the duty to aid the deprived as it relates to the basic right to health care is to enable right holders to recover from deprivations of health which would otherwise make it impossible for them to enjoy any of their other rights. The purpose of the five criteria is to provide an analytical framework with which to determine how best to achieve this goal, given the finite nature of resources, and the sometimes competing needs of different right holders. As a result of this goal there are three questions which analysis of the five criteria is intended to answer; first, which agents should be assigned responsibility for providing aid? Second, which cases of deprivation should receive priority? Third, what are the limits of the requirements of the duty to aid the deprived?

The five criteria operate together, and each has a different role in answering these questions. First, analysis of the liability and contingent ability criteria is intended to illuminate which duty bearers should be assigned responsibility

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[1] I only provide an overview of the role of the five criteria here, since deeper analysis would be redundant given the discussion of the previous sections.

for providing aid, in specific contexts and in general, and to show how duties to aid may be assigned based on capabilities to fulfil them. Second, analysis of the severity, AWS, and opportunity cost criteria is intended to show which cases should receive prioritised treatment in any given context. Third, analysis of the severity, contingent ability and opportunity cost criteria indicates where the limits of the requirements of the duty to aid the deprived are located. Each of these three criteria generates different aspects of these boundaries; the severity criterion defines the lower threshold, the contingent ability criterion defines the upper threshold for specific duty bearers, and the opportunity cost criterion defines the upper threshold of the duty in general.

Four general principles of the duty to aid the deprived can be derived from these functions;

1. Responsibility for providing aid to deprived persons should be allocated in the first instance to those responsible for causing or failing to prevent the deprivation. Where these parties lack the ability to aid, or where liability is not a factor, responsibility to aid is owed by those most able to provide it.
2. The duty only applies to deprivations caused by standard threats which are above a threshold of severity as defined by the extent to which the deprivation prevents the enjoyment of other rights. Priority is to be assigned to those cases which impose greater barriers to the enjoyment of other rights, or which minimise opportunity costs generally.

3. Duty bearers cannot be obliged to perform actions which exceed their contingent ability to do so or which impose excessive costs.
4. The duty can only demand that aid is provided to the extent which is compatible with the guaranteeing of rights to other important goods.

These four points are presented as general principles which define the role and requirements of the duty to aid the deprived. They are intended to provide an outline of how to fulfil the duty to aid the deprived as it applies to the basic right to health care in order to most effectively ensure the ability of right holders to enjoy the substances of all their basic rights. To this end, the principles emphasise the provision of aid to those victims of health deprivations which are most hindered in their abilities to enjoy other rights. In addition, the obligations imposed on duty bearers must be reasonable and compatible with their own status as right holders, in line with the contingent ability criterion. Further the upper threshold of the duty is defined by its compatibility with the provision and guarantee of the other basic rights.

In this section I have provided an overview of the way in which analysis of the five criteria proposed in this chapter can be used to decide which persons should receive aid in any given deprivation scenario. In addition, I argued that four general principles of the duty to aid the deprived can be derived from the preceding analysis of the five criteria, which can be used to define the general requirements of the duty.[1] Before I continue my discussion of the requirements of the duty to aid, in the following section I briefly set out how

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[1] As opposed to specific guidelines for behaviour in isolated contexts.

the five criteria discussed above can be used to set priorities for the duty to protect. Although that duty was the subject of the previous chapter, one of the goals of this chapter is to provide a framework with which it is possible to prioritise different interventions for the promotion and protection of health. Therefore, it is worth explaining how these five criteria can be used in the contexts of the other duties.

4.5 – The Five Criteria and The Duty to Protect

The five evaluative criteria can be used to set priorities for the duty to protect relatively straightforwardly. Although some of the criteria must be thought of in slightly different terms, liability becomes a matter of probability rather than definitive ascribable responsibility for example. Consideration of these five criteria can be used to determine the best allocation of resources for the protection and preservation of health. In this section I briefly set out how each of the five criteria can be applied to the duty to protect from deprivations of health. I do not attempt to provide a complete explanation of how each criterion relates to the duty to protect, since they do not differ significantly from how they function for the duty to aid. Indeed, in most cases their function is identical, with the only difference being that under the duty to protect the criteria are predictive rather than retrospective. However, it is worthwhile to briefly set out their functions here.[1]

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[1] I do not consider the role of the five criteria for the duty to avoid depriving because that duty does not entail a range of possible options as to how it may fulfilled. Instead,

Firstly, while the liability criterion might be thought to rely entirely on retrospective analysis of the agents with responsibility for causing deprivations, it can be applied to the duty to protect if it is applied as a predictive tool. For example, rather than being used as a measure of responsibility for harms caused, it could be used to predict the agents likely to be responsible for future harms and to assign responsibility for meeting these costs to those agents. For example, fines can be levied against those who drive recklessly, even if no persons were hurt, and income from such fines could be used to fund protective services such as speed cameras and the provision of other public services, while the fines themselves act as incentives to drive responsibly (thus encouraging compliance with the duty to avoid depriving). Indeed, there is a correlation between increased policing of traffic violations, and reductions in accident frequency, and fatalities caused by road accidents (Makowsky & Stratmann 2011, p.881).

Secondly, the severity criterion can be used to determine what kinds of protective services should receive priority since it may reasonably be thought that preventing more severe deprivations should take priority over the prevention of less severe deprivations. In this case what is evaluated is the expected severity of a given deprivation, which is used to help determine the importance of investing in services which protect against it and the amount of investment appropriate to the harm. For example, it is reasonable to suggest that significant investment into the control or elimination of tuberculosis is

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fulfilment of the duty to avoid depriving requires only that duty bearers not cause deprivation to others, a relatively straightforward demand.

appropriate because of the very severe consequences of the disease, the number of people it affects, and the duration of the deprivations suffered by its victims (Markowitz et al. 1997; Dye et al. 1999; Dye 2006).

Third, the AWS criterion functions in a similar manner to the severity criterion because of the close relationship between the two criteria. In a similarly predictive manner as the severity criterion in the context of the duty to protect, the AWS criterion considers the likely long term impact of failing to prevent different types of harms to health, and can be used to determine which preventative services should be prioritised. In addition, AWS can be used to determine the agents to whom protective services should be extended first, in a similar manner to the way in which it is used to evaluate the allocation of assistive services under the duty to aid.

Fourthly, the contingent ability criterion can be used to impose limits upon what duty bearers can reasonably be obliged to do in order to discharge their duties to protect other right holders from deprivation. It can also be used to assign responsibility for fulfilling any protective obligations to those agents most able to provide protection in a similar manner to its function for the duty to aid discussed above. Finally, the opportunity cost criterion can be used to choose between ‘competing’ protective services by evaluating the costs of providing alternative protective systems. Opportunity cost can also indicate the upper limits to the duty to protect based on evaluation of the expected benefits of a given protective intervention compared to its cost in terms of other services foregone as a result of providing it, a point discussed in more detail in the previous chapter.

The brief explanations offered in this section do not represent a full account of the roles of the five criteria as they apply to the duty to protect. Instead, my goal in this section has merely been to provide a general overview of the likely outcomes, in terms of general principles, of analysing the requirements of the duty to protect from deprivation with the five criteria proposed in this chapter. Further, as noted above, it is likely that the five criteria would generate similar theoretical outcomes for the duty to protect from deprivation as they do for the duty to aid the deprived. As such, a more detailed analysis is unlikely to add significant value to the thesis at this point, and would prevent discussion of more pressing issues.[1] Therefore, I shall leave my discussion of the applicability of the five evaluative criteria to the duty to protect from deprivation here.

In the following section I return to my discussion of the duty to aid the deprived and argue that the five criteria for evaluating deprivation scenarios provide a compelling argument for prioritising the provision of aid to the worst off. This argument is based on the claim that the deprivations suffered by the global poor strongly fulfils each of the five criteria. That is, deprivations are severe, yet are within the abilities of the global rich to treat, failure to treat carries high opportunity costs, there is a strong liability claim

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[1] Indeed, providing a full analysis of the duty to protect from deprivation in terms of the five criteria would require far more analysis than is possible in this chapter.

attached to at least some of the deprivations, and the aggregate welfare score of the global poor is generally far lower than that of the global rich. As such, they suffer the greatest barriers to the enjoyment of any of their rights and therefore are entitled to have their needs prioritised.

4.6 – Prioritising the Worst Off

In the previous sections I suggested a set of five criteria for evaluating deprivation scenarios in order to establish the extent of any duty to aid which may apply to them. I argued that these criteria can be used to differentiate between competing cases of deprivation in order to ensure that limited health care resources are used as effectively as possible, and in the most appropriate manner. In addition, I argued that the criteria generate four principles of the duty to aid which can be used to define the general requirements of the duty. In this section I argue that these principles indicate that the provision of aid to the global poor should be prioritised over the provision of aid to wealthier persons. I argue for this claim with reference to each of the five criteria proposed in this chapter. I argue for the prioritisation of the world’s poorest in very general terms, and only as a way of demonstrating the likely consequences of adopting the framework I have suggested in this chapter.

First, as was argued in chapter two, many of the deprivations suffered by the global poor are the result of the legislative and economic behaviour of powerful, wealthy nations which cause or exacerbate poverty and expose deprived persons to increased risk (Ramsay 2001, p.1348; Pogge 2008c, pp.118–122; Brock 2009, p.125; Wenar 2008, pp.2–3). For example, the problem of drug resistant infectious diseases is at least partly the result of ineffective global public health policy which has failed to adequately manage the use of antimicrobial medicines (L. B. Reichman 1996; Faustini et al. 2006). Therefore, given the involvement of wealthy nations in causing deprivations of health through the exacerbation of poverty, the denial of access to needed medicines (Gana 1996; Oddi 1996; Barton 2004), and the creation of severe health threats (Cosgrove & Carmeli 2003; European Surveillance of Antimicrobial Consumption 2010; Fong 2013), it is possible to argue, as Pogge does (2008c, pp.10–13), that there are obligations based on liability to the world's poorest people.

Secondly, as has been noted in this and the previous chapters, poorer and more socially deprived people (Rubel & Garro 1992; Karlsen & Nazroo 2002; Pelling 2003; Wilkinson & Marmot 2003; Venkatapuram et al. 2009) are the most likely to suffer deprivations of their health and are more likely to suffer more severe consequences as a result of such deprivations (Ryan 1971, p.p.170; Banta 2002; Grogan & Gusmano 2007; Buchman 2012). Indeed, the disparities which exist between global rich and global poor, and the deprivation experienced by the latter in absolute terms is such that providing aid to the poor should be prioritised over aid to the wealthy because the aggregate health welfare scores of the former are so low as to overshadow at least some of the importance of the other criteria.[1] As such, poorer people are

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[1] Indeed, Venkatapuram has recently argued that where the capability to aid the poor does not currently exist, research should be diverted towards finding solutions to such failures in our capability (2011, p.20).

likely to have lower AW scores in general, and thus to suffer more severe deprivations of their health which impose greater barriers to their enjoyment of their basic rights (Yilmaz & Raynaud 2013).

Third, while providing basic health care aid to the world's poorest people is likely to be extremely costly, arguably failure to do so will generate even greater costs in terms of restrictions on economic growth, and the development and spread of extremely dangerous epidemiological hazards (Welch et al. 2007). I discuss these points in more detail in the following chapter. Further, while costly, the provision of basic health care aid to all persons is likely to be within the abilities of the global rich, given the low cost of treatments which are likely to generate significant benefits for the poor (Dasgupta 1993, pp.92–93; Hotez et al. 2009). As such, there are significant opportunity costs associated with failing to provide aid to the poor, though doing so is likely to be within the abilities of the global rich, and will generate significant positive outcomes, which will offset costs.

Each of these factors speaks to prioritising the provision of aid to the worst off - many of the harms they face are at least partially the result of negligent or partial economic and legislative practice on the part of wealthy nations. Further, such harms are often extremely severe, and inhibit abilities to enjoy other rights. Many of the most prevalent harms suffered by the global poor, such as tuberculosis and malaria, are also treatable or preventable at relatively low cost (Reichman 1997), and the failure to do so carries significant opportunity costs. Prioritising the provision of aid to the worst off is also in keeping with the demands of the basic rights model, and Shue's sufficientarian emphasis on guaranteeing a minimally decent life for all persons. Since the people who the five criteria indicate we should aid are likely to fall below any reasonable definition of what a minimal decent life entails, and to have been denied their other basic rights to at least some extent, prioritising the provision of aid to them is in keeping with the general aims of the basic rights approach.

My goal in this section has not been to provide a comprehensive justification for prioritising the health care needs of the world's poorest people, but rather to provide a very brief outline of such a justification, and to show how such an argument might be based on analysis of the five criteria proposed in this section. In the following section, I summarise the arguments presented in this chapter.

4.7 – Summary

I argued at the beginning of this chapter that the duty to aid is an essential prerequisite of the basic right to health care and that failure to fulfil this duty is likely to lead to severe deprivations of health and wellbeing. In addition, as I also argued in chapter one, even in cases where it is never actually required, lacking a guaranteed entitlement to aid drastically undermines the utility of the basic right to health care. My goal in this chapter has been to demonstrate the importance of the duty to aid the deprived for enjoyment of a basic right to health care, and to set out general principles of what the duty requires. To do so, I first argued for the importance of the duty to aid in the general context of guaranteeing any basic rights, and noted that the consequences of failing to fulfil this duty can be extremely severe for those denied assistance. Second, I suggested a set of five criteria for evaluating health deprivation scenarios in which the duty to aid the deprived might be owed. In doing so I set out in general terms the importance of each of these criteria and the way in which they might be applied to deprivation scenarios in order to determine whether a duty to aid exists in a given situation. The criteria can also be used to determine the extent of the obligations owed to right holders in a given scenario, and the agents who are responsible for fulfilling them. I also briefly explained how these five criteria can be used to prioritise interventions under the duty to protect. In addition, I proposed four general principles, derived from the five criteria, which define the general practical requirements of the duty to aid the deprived. Finally, I have attempted to demonstrate how Shue's duty to aid the deprived is relevant to, and can be applied in, the global health care context and to thus show the duty's applicability to the basic right to health care.

As I noted earlier in this chapter, the potentially vast breadth of situations in which the duty to aid might apply makes it challenging to establish general principles of when and by whom aid must be given. As such, although Shue does suggest three categories of person to whom the duty is owed (1996, p.60), this says little about what the duty requires, especially in the health care context. In providing a set of criteria for evaluating situations in which the duty might be owed, I have attempted to construct an effective model for addressing this problem. The criteria discussed in this chapter are intended to provide a method for establishing guidelines for the duty to aid as it applies to the basic right to health care. These criteria are intended to ensure that appropriate aid is provided to those in need by the people most suited to providing it, in a manner which is not excessively demanding, and which generates the best outcomes reasonably possible given the limited nature of resources for health. Further, I have argued that in most cases, priority should be assigned to providing aid to the world's poorest people as a result of the significant deprivations of health (and welfare more generally) that they endure, and the causal role that the global rich have in perpetuating such deprivations.

In this and the preceding two chapters I have offered an overview of the importance of each of Shue's three categories of duty alongside a statement of the demands of those duties. I have argued that the duty to avoid depriving requires a complex set of behaviours from duty bearers, which extend beyond merely refraining from deliberately causing harm. In addition, the duty to protect from deprivation entails that duty bearers may in some circumstances have obligations to preserve public goods by forsaking desirable goods, such as some personal liberty in order to ensure that all persons enjoy the protection to which they are entitled under the basic right to health care. Finally, I have argued that compliance with the duty to aid requires significant action on the part of duty bearers, but that in some contexts where aid may be needed, it is not in fact required by the duty. These chapters have each attempted to provide one aspect of a full description of the requirements of the basic right to health care, and collectively should be taken as an outline of how duty bearers should fulfil their obligations to right holders. In the following chapter I consider some objections to my general argument for the basic right to health care and its requirements.

CHAPTER FIVE

OBJECTIONS TO THE ARGUMENT FOR THE BASIC RIGHT TO HEALTH CARE

> *In this chapter, I discuss four categories of objection to my argument for a basic right to health care; first, that the globalisation inherent to my argument is objectionable on cultural or ideological grounds. Second, that rights based theories are overly individualistic, and fail to take account of the importance of group goods. Third, that it is unnecessary to delineate a basic right to health care from Shue's basic right to subsistence, since Shue's model already accounts for this right. Finally, that claims for any global duties are flawed. In examining these objections my goal is to demonstrate the resiliency of my argument for the basic right to health care, and the utility of the basic rights model as a framework for theorising about global justice.*

In the preceding chapters I explained how Shue's triumvirate of duties could be understood to function if a basic right to health care were endorsed. In doing so, I argued that deprivations of health can make enjoyment of all other rights impossible, and that the duties operate to avoid, prevent, or ameliorate such deprivations. I also described in general terms the requirements of each of the three duties, and suggested several practical methods for fulfilling these requirements with reference to a range of prophylactic and therapeutic interventions for health. In addition, I offered a set of five criteria for evaluating situations in which aid might be owed with reference to several examples, and suggested how these criteria could be used to define general guiding principles for the duty to aid the deprived. Further, I suggested that these criteria can also be used to evaluate the extent of the duty to protect from deprivation.

My goal in this thesis has been to argue that health is of equivalent universal, instrumental importance to things like physical safety and economic security, and that as such, it is necessary for the enjoyment of all rights, and any decent life. Consequently, I have argued that there is a basic right to health care to which all persons are entitled. I have also attempted to demonstrate how a basic right to health care is compatible with, and required by, Shue’s model of basic rights and duties. In mapping out the theoretical and practical requirements of the basic right to health care I argued that Shue’s model of basic rights provides an effective way of discussing global health care justice and that it offers an effective method for responding to global health needs through the correlating triumvirate model of duties that Shue proposes. However, there are a number of objections which could be levelled against the model proposed in this thesis. In this chapter I attempt to anticipate and respond to such critiques.

In this chapter, I discuss four categories of objection to my argument for a basic right to health care; first, that the globalisation inherent to my argument is objectionable on cultural or ideological grounds. Second, that rights based theories are overly individualistic, and fail to take account of the importance of group goods. Third, that it is unnecessary to delineate a basic right to health care from Shue's basic right to subsistence, since Shue's model already accounts for this right. Finally, that claims for any global duties are flawed.

Of these categories of objection, the first two apply to any rights theory but may be resolved due to the unique features of Shue's model. The third category of objection to my approach focuses more specifically on my argument for a distinct basic right to health care, and the distinction I make between the basic rights to subsistence and health care, while the last objection is predicated on a rejection of any obligations to other people. While it will not be possible to provide full refutations for each of these objections here, since each objection could be the subject of extensive research itself, I offer a brief overview of possible responses to them.

In the following section I discuss the first category of possible objections to my argument for a basic right to health care; the objection from the inappropriateness of the globalisation of human rights.

5.1 - *Human Rights, 'Western' Values, and Cultural Incompatibility*

In this section I respond to the objection that rights based theories, and the personal entitlements to specific goods which they guarantee are inappropriate for 'non-western' contexts, and represent a form of 'moral neo-colonialism' (Widdows 2007, p.305) on the part of rights advocates (Tharoor

1999, p.1).[1] Conversely, Sumner B. Twiss has argued that the development of the Universal Declaration of Human Rights (UDHR) (UN General Assembly 1948) featured consultations with a wide range of cultural and ethical traditions, and is therefore not a merely western, liberal-democratic construct (2004, pp.58–59). There are two strands to the objection to human rights as a global justice paradigm; first, that some of the goods to which rights advocates claim there are rights, such as equality, education, freedom of religion, or the electoral franchise, are incompatible with certain cultural contexts (Polisi 2004, pp.41–43; Franck 2001; Cherif 2010). Second, the idea of rights themselves, as guarantees of individual entitlement, are hostile to cultural values which prioritise group membership, and communitarian ideals (Dallmayr 2002, p.182; Widdows & West-Oram 2013b, pp.55–56).[2] I address these claims in turn, and argue that neither offers a compelling objection to my argument for a basic right to health care.

First, Michael J. Perry has described the argument that certain goods are not valued by particular cultures as the ‘relativist challenge’ to human rights (1997, p.462). Perry characterises this objection as the claim that the value or disvalue of certain goods is dependent upon the context in which a person exists, rather than any shared innate characteristics of human beings (1997, pp.468–469). That is, there are no things which are universally bad, and should not be done to anyone, and no things which are universally good, and

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[1] See also (bin Mohamad et al. 1996, p.82), cited in (Barr 2002, p.7).

[2] Similar objections have also been direct at bioethics (Chattopadhyay & De Vries 2008, pp.106–107).

should be provided to everyone.[1] According to this interpretation, certain substances of rights are incompatible with a given culture, and/or are not valuable to those living within it. Examples of such ‘incompatible’ goods include gender equality (Franck 2001, p.191), reproductive health care services (Supreme Court of the United States 2014), religious freedom (Pagden 2003, pp.171–172), democratic participation (Sen 1999, pp.231–232; Caney 2005, pp.84–88), or access to education (Polisi 2004, p.42).

There are two responses to objections to specific human rights claims; First, that the advocates of particular views of the nature of a culture and its perspective on specific goods do not present an accurate representation of the cultural values they claim to espouse, and that they do not necessarily speak for all members of a given culture. This point has been discussed by Catherine E. Polisi, who argues that violations of women’s human rights in predominantly Islamic or Hindu countries are not the result ‘of the original interpretations of the scriptures, but rather subsequent male interpretations of these texts’ (2004, p.41). The justification for misogyny in these contexts is not based on cultural grounds, but on the decisions of people, and specifically men. Thomas M. Franck has articulated this point by noting that it

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[1] Perry’s description of this point is slightly more complex; ‘there are no things that ought not to be done (not even any things that *conditionally rather than unconditionally* ought not to be done) to any human being and no things that ought to be done (not even any things that *conditionally rather than unconditionally* ought to be done) for *every* human being. That is, no putatively "human" right is truly a *human* right: no such right is the right of *every* human being; in that sense, no such right - no such "ought" or "ought not" - is truly universal’ (1997, p.462).

> 'often turns out that oppressive practices defended by leaders of a culture, far from being pedigreed, are little more than the current self interested preferences of a power elite. If Afghan women were given a chance at equality, would they freely choose subordination as an expression of unique community values? We are unlikely to find out'
>
> (2001, p.197)[1]

The second response to the 'relativist challenge' to the content of specific human rights (Perry 1997, p.462) is that it is evidently false that there are no things which are inherently harmful or inherently valuable to all persons. This is not to suggest that it is necessarily possible to identify a way of life which is good for all human beings, a point Perry emphasises (1997, p.471), but it is possible to identify specific goods which are of value to all persons in all contexts.[2] While some goods may not be valued by some persons, certain things, such as the substances of the basic rights, are inherently valuable and necessary for any life, even if that life exists in a culture whose dominant leaders reject human rights theory. Indeed, in such contexts, Charles Taylor has suggested that it may be possible to reach agreement on

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[1] This is not to suggest that if misogyny were mandated by religious doctrine that it would somehow be acceptable, but rather to note that an appeal to the value of a specific cultural tradition or the incommensurability of metaphysical religious truths is not valid in these cases.

[2] Equally, there are numerous things which are inherently harmful to all human beings, a point Perry demonstrates with reference to the atrocities perpetrated against Bosnian Muslims in Bosnia and Herzegovina in the 1990s (Perry 1997, pp.469–470). Other examples might include the persecution and genocide of Jews by the Nazi regime, the systematic disenfranchisement and persecution of women in Afghanistan by the Taliban (Franck 2001, p.191), or the ongoing oppression of Muslims in Palestine (Lesch 1979; Mansour 2009; Journal of Palestine Studies 2009; Feldman 2009).

norms of behaviour, while retaining very different beliefs about the justification of such behaviour (1999, p.101).[1]

An entitlement to basic health care services is arguably a paradigm case of an entitlement which is of value to all persons in all contexts, and thus would appear to be easily supportable through Taylor's argument. However, the recent US Supreme Court decision to allow corporations to 'opt-out' of providing basic reproductive health care services to their employees through employer insurance contributions because of their deeply held religious convictions suggests that health care is not as uncontroversial as might be thought (Supreme Court of the United States 2014). The findings in *Burwell v. Hobby Lobby Stores Inc.* sustain the argument that requiring individuals, or in this case corporations, to respect human rights to which they object would unjustifiably restrict their rights to religious freedom, or to cultural identity (Supreme Court of the United States 2014, p.21).

The claim in this case is similar to earlier objections to requirements to provide contraceptive and abortion care to employees on grounds of religious liberty (Bandow 2012; Dolan 2012). I have discussed such claims elsewhere when I argued that the religious liberty argument is unsustainable because of the severity of the potential harms which could be inflicted upon women denied access to safe contraceptive and abortion care, an entitlement which would impose only minor costs on duty bearers (West-Oram 2013, pp.242–243). The severity of these harms is sufficient in some cases to make it

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[1] See also (Messer 1997).

impossible for women denied access to these services to enjoy any other rights (Cates et al. 1977, p.267; Trussell et al. 1980, p.129; Grimes et al. 2006, p.1908; Weitz & Fogel 2010, p.9).[1]

Therefore, even if it is accepted that harm is caused to those forced to accept the existence of rights to basic health care services, such harms are less significant than the harm suffered by women denied access to such services in deference to cultural sensitivities; women denied access to contraception and abortion care are at risk of death and serious impairment of their ability to enjoy other rights, ideological objectors to the extent of the right to health care are not.[2] Consequently, entitlements to basic health care services cannot justifiably be rescinded in deference to ideological doctrine with which it is incompatible. Further, entitlements to basic health care services are vital to the enjoyment of all human lives in a way that the freedom to restrict the liberty of others is not. As such, to attempt to restrict rights to basic health care services, including rights to safe contraceptive and abortion care, is to remove one of the necessary conditions of enjoyment of the right to impose such restrictions, as argued in chapter one (Shue 1996, p.19).

So far in this section I have argued that there are good reasons to doubt the value of culturally based objections to specific entitlements guaranteed by

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[1] Supreme Court Justice Ruth Bader Ginsburg's strongly worded dissent to the court's decision in *Burwell v. Hobby Lobby Stores Inc.* emphasises concern over the effect that the wider application of the law will have on the welfare of women who are dependent upon their employer for access to contraceptive services and abortion care (Supreme Court of the United States 2014, p.64).

[2] It might also be questioned, perhaps uncharitably, whether Franck's concern that cultural practices are often 'little more than the current self interested preferences of a power elite' applies in this case (2001, p.197).

rights. I first argued that when considering the weight of objections to specific goods it is important to determine whether those objecting actually speak for all members of a given community. Secondly, I argued that cultural objections to specific goods should be assessed to determine whether they do in fact represent metaphysically grounded, and thus incommensurable, cultural principles, or whether they are instead merely the expression of the desires of self interested, powerful elites.[1] Third, I argued that at least some goods, of which health care is a paradigm case, are universally applicable, and that ideological objections to them are unsustainable because of the harms that deprivations of them cause, and the necessity of the basic right to health care for the enjoyment of all other rights. In the rest of this section I consider the second ideological-cultural objection to human rights as a model of global justice – that they are incompatible with communitarian focused societies.

Where the first objection to the global applicability of human rights doctrine focused on the lack of value of certain goods in specific cultural contexts, the second argument focuses instead on the nature of human rights as a theory focused on individual entitlements, rather than group goods. In the remainder of this section I examine claims that the individualistic focus of human rights doctrine is contrary to, and therefore incompatible with, the communitarian nature of some ‘non-western’ cultural identities.

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[1] This is not to suggest that all cases of value conflict arise from such intellectual dishonesty on the part of dominant groups within cultural paradigms, but rather to note that genuine ideological objections to specific goods may be significantly rarer than may be thought.

In doing so I shall first note a general criticism of this cultural incompatibility objection to human rights - that the claim is based on inaccurate interpretations of the nature of 'western' and 'non-western' persons and cultural identities.[1] Second, I shall argue, in what is the main focus of this discussion, that the inherently public or community focused nature of health care provision, the basic right to health care is compatible with even the least nuanced, and stereotypical account of communitarian cultural values.[2] This kind of objection to global application of the doctrine of human rights is exemplified by the so-called Asian Values Movement (AVM) which alleges that the individualistic focus of human rights contradicts the community or group focus of 'traditional Asian values' (Ames 1988, p.205).[3]

First, Amartya Sen has rejected as inaccurate the claim that liberal-democratic ideals are a uniquely 'Western' construct, or that the emphasis on personal freedom is alien to 'Asian culture' (a category which is not nearly as monolithic as the term implies) (1999, pp.232–240).[4] Sen supports this claim with reference to the importance of personal liberty, toleration, and freedom

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[1] I discuss this point only briefly, as they refer to rights theory generally, rather than to the basic right to health care which is the main focus of this thesis.

[2] While I focus on the arguments proposed by advocates of the AVM it has also been argued that rights talk as embodied by the Universal Declaration of Human Rights is, in part at least, compatible with Islamic philosophical thought (An-Na'im & Henkin 2000, pp.96–97). Indeed, as noted above, it has also been suggested that at least some Islamic opposition to human rights norms is based on the goals of powerful elites in certain groups, rather than on accurate interpretations of Islamic theology (Polisi 2004, pp.41–43; Mayer 2012). Indeed, Abul A'la Mawdudi has argued for the presence of rights norms in Islamic theological and philosophical doctrine, and criticised the view that rights are an innately 'western' concept (1976, pp.12–13, 17–22).

[3] For a more detailed discussion of the Asian Values Movement see (Widdows 2007, pp.307–308; Widdows 2011; Widdows & West-Oram 2013b, pp.54–58).

[4] See also (Bielefeldt 2000; Caney 2005, pp.84–88).

of speech in Confucian thought (1999, pp.232–235). He also notes the importance of egalitarianism and religious freedom in Indian philosophy (1999, pp.235–236).[1] Further, as argued elsewhere, and related to Sen's argument on the compatibility of Asian and 'Western' cultures, the depiction of European and American people as extremely individualistic, while their Asian counterparts are entirely communitarian grotesquely oversimplifies the nature of human beings (Widdows 2007; Widdows & West-Oram 2013b, p.56).[2] Indeed, the claim that 'Asian societies are authoritarian and paternalistic and so need governments that are also authoritarian and paternalistic' has been dismissed as 'racist nonsense' by Jose W. Diokno a former senator and opponent of military rule in the Philippines (Diokno 1978) quoted in (Shue 1996, p.66).

I have so far rejected the claim that there is a divide between western and non-western values which is so distinct as to make human rights norms inappropriate for application in non-western cultures. However, in the rest of this section I shall argue that while the classification of Asian culture as entirely communitarian and monolithic (Lee 1992, pp.252–253) is false, it can be argued that these stereotypical Asian values are compatible with the

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[1] Correlatively, it has also been noted that norms of personal freedom, religious liberty and freedom of speech are relatively recent additions to 'western' philosophical doctrine (Franck 2001, pp.199–200).

[2] Joseph Chan has also argued on similar grounds that to view Confucian philosophy as depicting persons as entirely social entities is mistaken, since 'there are strong nonrelational elements in the Confucian morality' (1999, p.218). Correlatively, Tom Campbell has argued that human rights do not necessarily entail 'radical egotism', and are compatible with right holder's positive, supportive involvement with their community (1999, pp.11–12). Franck makes a similar point and argues that despite the growing acceptance of individualistic rights doctrine, people still voluntarily choose to participate in new kinds of valuable community (2001, p.202).

community level participation required by many health care goods. That is, since Asian culture is alleged to prioritise the good of the community over that of the individual, health care goods which require individuals to prioritise the welfare of their group over their personal desires, of which there are many, would be acceptable in this cultural context.[1]

As discussed in the previous chapters, certain important requirements of the basic right to health care are overtly group focused and as such are compatible with the asserted communitarian focus of Asian cultural traditions. For example, health care systems are more effective if delivered through group participation and public funding than they are if funded privately, as I discuss in section 5.4 (Schoen et al. 2010; Anderson et al. 2012). Similarly, the preservation of antimicrobial efficacy requires group cooperation and careful management of the use of antibiotic medicines (Cars et al. 2008), and vaccination programmes require mass participation in order to be most effective (Salmon et al. 1999; Salmon et al. 2005). In addition, preserving and promoting these goods can require the denial of individual interests in order to provide better outcomes for groups as a whole, as I discuss in the following section.

In contrast to the individualistic focus of human rights doctrine, Asian values are claimed to prioritise the interests of the group or community (Ames 1988;

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[1] In doing so, I accept, for the sake of argument, the stereotypical view of Asian culture as communitarian, and Western culture as individualist. I do not, however, actually hold these stereotypes to be accurate, indeed I agree with Senator Diokno's assessment of them (Diokno 1978) quoted in (Shue 1996, p.66).

Lee 1992; Teik 2003). As such, it is plausible to suggest that the prioritisation of group interests required by certain important health related group goods is compatible with 'Asian values' given their asserted focus on the prioritisation of group, as opposed to individual, interests (Chattopadhyay & De Vries 2008, pp.107–108) and (bin Mohamad et al. 1996, p.82), cited in (Barr 2002, p.7). Indeed, it might reasonably be argued that certain of the group focused requirements of the basic right to health care, such as the regulation of access to certain kinds of medicine, or the collective provision of health care,[1] are more compatible with 'Asian values' than they are with the individualism of human rights theory more generally. This is because delivery of these kinds of health care good requires cooperative, group focused behaviour from duty bearers, something which might be seen as incompatible with pure individualism. In addition, my general argument for the basic right to health care explicitly asserts the existence and importance of extensive obligations owed by right holders to other people, a position which is very different to the individualistic focus of human rights discourse described by proponents of the AVM (bin Mohamad et al. 1996, p.82), cited in (Barr 2002, p.7).[2]

While human rights do typically provide guaranteed entitlements to individuals, the basic rights model explicitly asserts the importance of

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[1] Such as the preservation of herd immunity (Fine 1993; Garnett 2005), or of antimicrobial efficacy (Cars et al. 2008).

[2] As noted above, Chan has also rejected as inaccurate the view of rights as the domain of the purely selfish egoist, and has suggested that rights may be compatible with Confucian philosophical arguments which emphasise community relationships between persons (1999, pp.220–221)

assignable duties which impose obligations to contribute to the general provision of health care. As such, while my argument retains the welfare of individuals as a point of primary concern, it also asserts the importance of preserving group goods, and of serving group interests in the long term, as I discuss in the following section. As I have argued throughout this thesis, the effective provision of basic health care is in many cases a group project,[1] given the nature of threats to health, the methods by which health care is delivered most effectively, and the consequences of failure to deliver care effectively. As such, although I reject the communitarian arguments presented by the AVM as lacking sensitivity to cultural similarities, the basic right to health care that I have described in this thesis is compatible with even the least nuanced and inaccurate account of the communitarian nature of ‘Asian values’.

I have argued in this section that human rights based theories are a valid and effective method of discussing global health care justice. In doing so, I have rejected claims that rights based theories are inappropriate for the global context because of incompatibility with certain kinds of cultural context, and argued that the basic right to health care is especially compatible with cultural traditions which prioritise community interests over those of

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[1] John Coggon has rightly argued that while ‘every social determinant of health is under the State’s view, ... each is not ultimately the business of the State’ (2012, p.265). However, as discussed in chapter three, many basic health care services, such as vaccination, which promote individual health can only be delivered through collective group action, which I have argued is the business of the state. Further, I have also argued throughout this thesis that states have significant roles in delivering basic health care services, while individuals must contribute financially and behaviourally to their delivery. As such, while not every health factor is a matter for State involvement, at the level of basic health care, very many are.

individuals. In the following section I pursue an issue mentioned above, the difficulty of reconciling the individualistic nature of human rights with the importance of group goods for the preservation and promotion of health.

5.2 – The Basic Right to Health Care and Group Health Goods

In the previous section I examined the difficulty associated with globalising a system which is claimed to be ‘western’ and therefore incompatible with other cultures. While it is unclear that the individualistic nature of rights renders them inappropriate in ‘non-western’ contexts, there is an additional objection, based on the individual focus of rights, to which my argument for a basic right to health care may be vulnerable - that, because rights are focused on the entitlements of individuals, while group goods can only be enjoyed by groups (though provide significant benefits to the members of those groups), rights talk is incapable of accounting for group goods (MacCormick 1977, pp.204–205; Raz 1986, pp.198–199).[1]

In this section I argue that despite its focus on individual welfare, the basic right to health care is capable of imposing theoretically justified restrictions on individual entitlements to important goods in order to ensure similar rights for all persons. However, I also argue that the model will do so not out of recognition of group goods *qua* group goods, but rather because doing so is the most effective way to preserve and promote individual welfare long term.

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[1] This is an issue which has been discussed elsewhere in the context of a wider theoretical concern about the expansion of bounded theories of justice to the global setting (Widdows & West-Oram 2013a, pp.231–232).

To make this argument I first define group goods and explain their importance for individual welfare with reference to several examples. Second, I explain how the individualistic focus of rights based theories, including the basic rights model, may appear to render them incapable of adequately preserving group goods. Third, I offer two theoretical justifications of how the basic rights model can impose limits on individual entitlements to group health goods, whilst adhering to its focus on individual welfare.

The term ‘group goods’ describes a category of goods which are ‘non-excludable’ and ‘jointly produced’ (Waldron 1987, p.303).[1] This means that they can only be enjoyed collectively by groups, rather than privately by individuals, and can only be produced and maintained through cooperative action by ‘all or most’ members of the group which enjoys them (Waldron 1987, p.303).[2] A consequence of the second feature of group goods is that the actions necessary to preserve them may in certain circumstances not serve the specific interests of individuals at a given time. For example, as I discuss below, preserving the group good of antibiotic efficacy may require that individual rights to antibiotic medicines may have to be curtailed. While such restrictions may not serve individual interests in isolated contexts, preserving group goods is in the general interests of all individuals as I explain below.

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[1] Waldron notes that there are other features of public goods, although these two are those he considers most important.

[2] The non-excludability of group goods has been claimed to make individual rights to them impossible (MacCormick 1977, pp.204–205; Raz 1986, pp.198–199). This claim has been discussed, and to an extent rejected by Jeremy Waldron (1987, pp.301–305). However, it is the jointness of production of group good with which I am concerned in this section.

Examples of group goods which are also essential for the enjoyment of all rights include things like ‘unpolluted air’ (Shue 1996, p.23; Caney 2011), herd immunity (Anderson & May 1985; Fine 1993),[1] and antimicrobial efficacy (Wilson 2013).[2] Each of these goods cannot be enjoyed privately, and can only be maintained and preserved through collective, cooperative action. As such, they each meet Waldron’s criteria for qualifying as group goods. Further, since enjoyment of each of these goods is necessary for the enjoyment of any rights, these goods qualify as the substances of basic rights, meaning that right holders have guaranteed entitlements to them. However, excessive or inappropriate consumption or use of such goods can destroy or deplete group goods, rendering them unusable by right holders and making the enjoyment of rights impossible long term.[3] As such, in promoting individual rights to group goods, the basic rights model appears to contribute to the erosion of the goods it must protect in order to guarantee individual welfare.

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[1] Where the other goods mentioned here are destroyed by excessive or inappropriate consumption by right holders, herd immunity is destroyed by failures by right holders to contribute effectively to its maintenance, as I have discussed elsewhere (West-Oram 2013).

[2] For a more extensive list of examples, see (Widdows & West-Oram 2013a, p.234).

[3] The process by which group goods are destroyed by the consumption of them by those with entitlements to do so has been described by Garrett Hardin as the ‘tragedy of the commons’ (1968). This occurs when right holders enjoy entitlements to make use of a good which is shared by all persons. In the absence of an agent with responsibility for preserving the good, Hardin argues that such use will inevitably lead to the destruction of the good in question to the cost of all those with entitlements to the good. While Hardin’s argument is to an extent useful in this specific context, his wider argument has been discussed and rejected elsewhere (West-Oram & Widdows 2012). Importantly, as I discuss below, the basic rights model can impose responsibilities to preserve group goods in order to promote individual welfare.

To illustrate, access to antibiotic medicines is vital to the promotion of individual welfare and is necessary if right holders are to be protected from numerous potentially lethal, but (currently) treatable, diseases (World Health Organization 2007; Widdows & West-Oram 2013a, pp.235–236).[1] The severity and ubiquity of such diseases means they qualify as standard threats, and thus merit a response under the basic right to health care. Therefore, access to the medicines which prevent or cure this kind of disease appears to be an essential component of the basic right to health care. However, antimicrobial efficacy appears to be a finite resource, the depletion of which can be accelerated by excessive, inappropriate use of certain medicines (Harrison & Lederberg 1998; Wise 2002; World Health Organization 2012). This has been facilitated by asserted rights to these medicines (Widdows & West-Oram 2013a, p.236), which has contributed to the development of a problem which is extremely dangerous, and global in scale (Ormerod 2005; Cosgrove 2006, p.s83; Welch et al. 2007, p.e309; Battin et al. 2009, p.230). In this case, the claimed rights of individuals to sell and consume antibiotic medicines has 'trumped' (Widdows & West-Oram 2013a, p.237) the need to preserve antibiotic efficacy for long term group use (Wilson 2012; Wilson 2013). This has had the effect of depleting the group good antimicrobial efficacy, while also exposing individuals to far greater threats to their health in the short, medium, and long term.[2]

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[1] See also (Iseman 1993; Reichman 1997).

[2] An alternative example of a basic health group good is herd immunity, which can also be depleted by the actions of individuals. However, where antimicrobial efficacy is

Protecting right holders from the harms caused by the depletion of the group good 'antimicrobial efficacy' requires careful management of antimicrobial medicines which may entail restricting access to these drugs (Wilson 2012; Wilson 2013; Wise 2002). Failure to do so would undermine our ability to protect people from severe harm caused by drug resistant diseases.[1] However, while unrestricted access to antimicrobial medicines is incompatible with the preservation of the group good and the promotion of individual welfare, limiting access to antimicrobial medicines appears incompatible with rights as guaranteed entitlements, *and* exposes right holders to the risk of harms which have the potential to make enjoyment of any rights impossible (Pogge 2008a). This is a dilemma which the basic rights model may appear unable to resolve.

The widespread, unmanaged use of antimicrobial medicines contributes to the accelerated evolution of drug resistant diseases. However, denying right holders access to antimicrobial medicines would make it impossible for right holders to have the guarantees of the actual enjoyment of other rights with which the basic rights model is concerned. These alternatives present a seemingly irreconcilable problem for my argument for a basic right to health care since providing the guarantees the right demands is incompatible with

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undermined by the excessive consumption of antibiotic medicines, herd immunity is depleted by failures to participate in preserving it. These failures are excused on grounds of personal freedom to control one's personal medical care, as discussed elsewhere (West-Oram 2013). However, failure to participate in vaccination programmes undermines a good which is of fundamental importance to all persons (Feikin et al. 2000; Salmon et al. 2005; Salmon et al. 2009), and which protection against significant harms. In this context, it is absolute prioritisation of rights to personal freedom, rather than to the group good itself, which make enjoyment of group goods impossible.

[1] It would also cause significant harm to individual health prospects.

preserving the goods to which the right entitles right holders. Therefore, it appears that the basic rights model is incapable of accounting for the importance of group goods in preserving individual welfare. While this seems an insurmountable problem, a solution is possible as I discuss below.

While the basic rights model provides guarantees of individual entitlements, these guarantees can be limited in a manner compatible with the preservation of group goods. In doing so, the basic right to health care will guarantee entitlements to the goods necessary to promote individual welfare, but only to the extent compatible with the preservation of the goods to which there are rights. That is, the purpose of limiting the guarantees provided by the basic rights is to ensure the effective management of a finite resource and thus effectively promote welfare long term. This can be justified in a manner compatible with the basic rights model for two reasons.

First, according to Shue, even the basic rights do not provide absolute guarantees of protection or assistance in times of need. As argued in chapter one, the guarantees provided by the basic rights are ‘realistic’ not ‘utopian’ (Shue 1996, p.32). This means that the extent of guarantees provided by rights can be shaped by empirical factors such as the finite nature of group goods. Therefore, even though group goods are seen ‘merely’ as finite resources by the basic rights model, it will still impose limitations on their consumption in order to preserve them for the enjoyment of individuals. These limitations on rights are compatible with the theoretical framework of the basic rights model. While the right to health care does guarantee certain entitlements, it does so while implicitly acknowledging that those entitlements must be limited by the needs of all right holders, and not just those immediately present in any given allocation scenario.[1] As such, the entitlements provided by the basic right to health care are limited to what is feasible and appropriate given the health care needs and rights of other agents. This is compatible with the protection of basic individual welfare, the preservation of group goods, (albeit not as group goods, but 'merely' as finite resources which are the substances of individual rights) and with the complex realities of resource allocation in the global health care context.

Secondly, a Rawlsian claim that rights entitle right holders only to a set of goods which is 'compatible with a similar scheme for all' (1999a, p.53) can be applied to the basic right to health care and to basic group health goods. While guaranteeing unrestricted access to such goods may appear to be the purpose of a basic right to health care, such absolute entitlements are incompatible with all persons having similar rights. As such, it is justifiable, on grounds of promoting individual welfare for all persons, to restrict the extent of entitlements to certain goods. Failure to do so is incompatible with guaranteeing a similar scheme of health care provision for all persons.[2] As

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[1] I discussed the importance of considering the opportunity costs of different resource allocations in chapter four. That discussion is equally relevant here, since the impact on all right holders of failing to restrict access to antibiotic medicines can be disastrous. Therefore, the medium and long term impacts of the use of antibiotic medicines are relevant factors to consider when making resource management decisions about the accessibility of antimicrobial medicines.

[2] This may be seen as a type of Kantian argument, since claims to absolute entitlements to certain types of public good cannot be universalised because providing those entitlements would undermine the general system by which health care is provided. As such, entitlements to certain types of public goods in certain circumstances cannot be treated as a universal law, since doing so would render the general provision of those goods

such, it can be argued that while there is a basic right to health care, which does provide certain guarantees, the individual entitlements it provides are not absolute and confer entitlements only to the extent that they do not infringe upon the rights of other right holders. Therefore, while the basic rights model does not recognise group goods *qua* group goods, protecting individual basic rights is not necessarily incompatible with the preservation of group goods *qua* finite resources.

However, this Rawlsian condition should not be thought to impose limits on the basic right to health care as a result of isolated instances of resource scarcity. That is, it does not require that in cases where two persons require aid, if it is not possible to provide aid to both, that it should be provided to neither because access for either is incompatible with similar access for all. To illustrate, a general right to surgery is possible even if in a specific instance the only available surgeon can only operate on one of two equally needy and entitled patients, the difficulty lies in determining which to prioritise.[1] That is, just because we cannot fulfil all rights claims at specific time *t* does not mean that the rights claim does not meet the compatibility criterion at all other times. However, I proposed an analytical framework in the previous chapter which is intended to resolve such problems of priority setting.

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impossible. Therefore, such demands fail to meet the requirements of the first formulation of the categorical imperative (Kant 1998, AK 4: 421).

[1] It should be noted that the fulfilment of even the basic right to health care would likely require massive reorganisation of existing health care provision structures, and may require that we reduce the services available to citizens of wealthy countries in order to fulfil the basic rights of the poor. This is obviously not an uncontroversial demand.

Both of these arguments focus on the preservation and promotion of *individual* welfare, and refer to the preservation of group goods (as finite resources) only as a means to provide better protection to more people. Further, they both provide theoretical justifications, which are compatible with individual rights, for imposing restrictions on the extent of individual entitlements to certain basic health goods. As such, the preservation of group goods is achieved as a side effect of the promotion and protection of individual rights.

In this section I have suggested the outline of one possible response to the apparent conflict between group goods and individual rights - that the basic rights model will limit the entitlements guaranteed by the basic rights in order to promote basic individual welfare for as many people as possible. In doing so the basic rights model will, as a side effect, also safeguard basic group health goods. In the following section I discuss the third category of objection to my argument for a basic right to health care; the idea that health care should not be seen as an independent basic right, but rather merely as one subsidiary feature of the basic right to subsistence.

5.3 – The Importance of a Distinct Basic Right to Health Care

In the previous sections I have argued that the basic rights model is an appropriate and effective way of addressing questions of global health care justice. In doing so I defended the model against two types of objection levelled against rights theory; first, that human rights are inappropriate for certain cultural contexts; and second, that theories of rights cannot adequately protect group goods because of their commitment to the entitlements of individuals. Both of these claims are addressed to rights based theories of justice generally, and I argued against them in these terms. However, in both cases I also noted that the basic right to health care is especially resistant to the force of these claims because of the unique features of the basic rights model and of the focus of the basic right to health care.

In this section I consider a different type of argument which, rather than challenging rights based theories as valid approaches to global justice, focuses instead on the value of distinguishing the basic right to health care from the basic right to subsistence. In doing so, I argue that while Shue does assert the importance of 'minimal preventative public health care' (1996, p.23) as part of the basic right to subsistence, there is value in separating out the basic right to health care from the basic right to subsistence. To make this argument I first restate Shue's original evaluation of the health care requirements of the basic rights and argue that while a broad interpretation of his statements on health care might imply an endorsement of a comprehensive right to health care this is not made explicit by Shue. Second, I suggest that even if my argument for a distinct basic right to health care is unconvincing, and health care is deemed to be an aspect of the basic right to subsistence, the arguments presented in this thesis are still valuable as a way of explicating the health care requirements of the basic rights model. Third, I argue that treating health care as the substance of a distinct basic right provides valuable clarity to the basic rights model which speaks to its status as at least a 'quasi-basic' right.

First then, as noted in chapter one, Shue states that the basic right to subsistence entails the provision of numerous goods including 'minimal preventative public health care' (1996, p.23). This may seem limited, given the importance of assistive health care service as discussed in the previous chapters. However, Shue also states that while the basic right to subsistence does not mean that 'every baby born with a need for open-heart surgery has a right to have it, but it would also not count as adequate food a diet that produces a life expectancy of 35 years of fever-laden, parasite-ridden listlessness' (1996, p.23). In addition, he argues that 'we may have very little excuse for allowing so many poor people to die of malaria and more excuse probably for allowing people to die of cancer' (1996, p.33), implying that at least some assistive health care services are required by the basic right to subsistence. Therefore, the utility of distinguishing a basic right to health care might be questioned, given that Shue already asserts the importance of protective and assistive health care measures. I suggest two responses to this claim below.

Second, in response to the above claim I first contend that even if the basic right to subsistence is taken to provide the full range of health care services necessary to ensure that all persons are adequately guaranteed against standard threats to health, discussing the health care requirements of the basic rights model in more detail adds valuable clarity to a complex issue. If a distinct basic right to health care is rejected in favour of including health care under the basic right to subsistence, the arguments for the duty requirements of a distinct basic right to health care offered in the previous chapters might instead be thought to describe the requirements of a subsidiary element of the basic right to subsistence. Therefore, setting these requirements out in the manner of the previous chapters is still valuable because it makes explicit those requirements which Shue leaves implicit. In doing so my argument clarifies the health care requirements of the basic rights model. Consequently, my argument for the importance of certain basic health care services, and my discussion of the specific health care requirements of the triumvirate of duties in the previous chapters remains valuable even if a distinct basic right to health care is rejected.

If the argument for an expanded entitlement to health care under the basic right to subsistence were accepted, the discussion in the previous chapters might be taken to instead provide an outline of a reasonable and practical set of health care entitlements, applicable under the basic right to subsistence. However, while the outcomes of treating health care as a subsidiary aspect of the basic right to subsistence *may* be similar to those of acknowledging a distinct basic right to health care, distinguishing the two rights is more appropriate given the structural similarities of the basic right to health care and Shue's original basic rights, as I now argue.

The second response to the rejection of a distinct basic right to health care is derived from a point I noted in chapter one - that each of the basic rights described by Shue are similar to a category of right proposed by Judith Jarvis Thomson – 'cluster rights' which are primarily defined by the fact that they ‘contain’ other rights (Thomson 1992, pp.54–55).[1] They have this status because each ‘contains’ subsidiary rights to goods which collectively provide the substance of each right. As I have argued throughout this thesis, the basic right to health care contains many subsidiary rights, which collectively serve to guarantee the substance ‘health care’ and to thus guarantee the health of right holders. As such, the basic right to health care also qualifies as a cluster right in the same manner as the rights to liberty, security, and subsistence. As such, assigning it equal priority with the original basic rights groups these ‘cluster rights’ together, and is thus clearer than treating health care as a subsidiary entitlement of the basic right to subsistence.

Each of the basic rights originally described by Shue can be defined as cluster rights, because they describe a set of entitlements, or subsidiary rights, which collectively serve to provide the substance of each right. Put differently, each subsidiary right might be described as a token of the type of the category to which they belong. For example, a right to police protection is a token of the type (or cluster) security rights, while a right to democratic participation is a token of the type, liberty rights. While some of the subsidiary, or token, rights may contain sets of their own tokens, a right to unpolluted air may involve subsidiary rights to reduced carbon emissions for example (Gössling et al. 2007; Murtaugh & Schlax 2009; McKercher et al. 2010), these categories are significantly smaller than those which are the objects of Shue’s basic rights. However, unlike the other subsidiary rights of the basic right to

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[1] This is also similar to Sridhar Venkatapuram’s suggestion of health as a ‘meta-capability’ (2011, p.20).

subsistence, the right to health care includes a large number of complexly interrelated subsidiary rights in the same manner as Shue's original basic rights.

For example, rights to treatment for infectious disease and to preventative social structures (Vitek & Wharton 1998; Poland & Jacobson 2011) can each be described as token health care rights. Other token health care rights might include rights to sanitation (Ewald 1994, p.67; Daniels 2008, p.142; Nandy & Gordon 2009), medical facilities (Hurley et al. 1997, p.1797), or appropriate social services (such as the provision of free condoms). As such, the right to health care is structurally very similar to Shue's original basic rights, both because it describes a category of rights, and because of the large number of token rights which fall into that category.[1] Therefore, assigning equal status with the original basic rights to the right to health care, to treat it as a basic right, has value because it groups structurally similar rights together, and thereby provides greater clarity to the basic rights model than is possible through retaining the right to health care in the basic right to subsistence. Retaining Shue's original structure of the basic right to subsistence, even with expanded health care entitlements, also obscures the importance of health care for living a decent life, and adds an additional layer of complexity to the basic right to subsistence. Therefore, it is reasonable, purely in terms

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[1] As discussed in the previous chapters, each of the duties correlating to the basic right to health care as I have argued for it requires an exceedingly complex arrangement of interconnected obligations.

of theoretical clarity, to assign the right to health care the same status and position as Shue’s original basic rights.

I have argued in this section that assigning equal status to the basic right to health care is appropriate for both theoretical and practical reasons; first, I argued that even if my argument for a distinct basic right to health care is rejected, the discussion in chapters two to four of the duties correlating to the basic right to health care retains its utility, though as a statement of the requirements of a subsidiary entitlement of the basic right to subsistence, rather than of a distinct basic right to health care. Second, I argued that the basic right to health care is structurally similar to the basic rights proposed by Shue. Therefore, by grouping it with them it is possible to clarify important aspects of the basic rights model.

In the following section I provide a self interested argument for the provision of basic health care services for all, based on epidemiological and economic arguments.

5.4 - Rejecting Rights to Health Care, and Rejecting Global Duties

The objections I have offered so far have each presented a unique concern about the nature of the basic right to health care proposed in this thesis. However, while each objection has a different focus, they share a similarity in that they are all compatible with recognition of some kind of obligation to guarantee some health care interventions to everyone. In contrast, the final category of objection that I consider in this chapter focuses instead on rejecting a right to health care that entails any duties to provide aid or assistance to other persons. There are two ways that this objection to the basic right to health care may be expressed; first, that the cost of providing care is prohibitively high, and imposes unreasonable obligations on duty bearers (Rorty 1996, pp.10, 14–15) cited in (Pogge 2008c, pp.7–9). Second, that there are simply no duties to other persons, regardless of the importance of health care for a decent life. In response to these claims, in the following sections I argue that there are at least two significant advantages associated with guaranteeing accessible health care to all persons. These advantages are such that even if moral duties to provide health care to others are rejected there are good, self-interested reasons to ensure universal access to health care.

Both expressions of the objection to the existence of duties to other persons can be expressed in more or less extensive terms; firstly, that while there are obligations to our co-nationals, there are no obligations to those who live beyond the borders of our home nation. The second, stronger, variation of this objection rejects the existence of any but the most passive obligations to other persons regardless of where those persons live. This second objection might be seen as extreme but it is a position which has been expressed frequently in the United States of America during the recent debates over the morality and legality of the Patient Protection and Affordable Care Act (PPACA) (Patient Protection and Affordable Care Act 2010) and has been discussed elsewhere (West-Oram 2013).[1] Both of these positions may be defended, I argue unsuccessfully, on practical or theoretical grounds. That is, obligations to distant others may be rejected either because they would be excessively costly, or because no such duties exist. Equally, the existence of duties to any persons may be rejected on similar grounds.

While these two positions differ in their scope, they each reject the idea of obligations to provide health care, either for anyone, or for those outside of a specific group. In either case, both claims can be rejected in a similar fashion. An appeal to the moral status of individuals or the universal need for health care is unlikely to be convincing to those who fundamentally reject the idea of rights to health care. Therefore, in responding to these objections I focus mainly on the empirical claim that even if obligations to provide basic health care services are rejected, there are good economic and epidemiological reasons to ensure that health care is available and accessible for all.

My goal in these sections is not to argue that the costs of providing a basic right to health care will be insignificant, since they are very likely to be extensive, at least in absolute terms. Instead, I merely wish to argue that providing health care to all persons will generate significant benefits that offset the costs of provision, even for those capable of providing their own

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[1] Indeed, the position that there are no moral obligations to assist other people in the context of health care was endorsed by all candidates in the recent US Republican party presidential primary elections. See for example (Ron Paul Presidential Campaign Committee 2011; Rick Santorum for President 2011; Romney For President, Inc. 2012).

care privately. However, it is also worth noting that it is not necessarily the case that the cost of health care, for at least some major deprivation hazards, will be prohibitively expensive. For example, Dasgupta has noted that in the 1970s, despite massively lower annual spending on health care than the USA ($6/person compared to $2500/person), Sri Lanka achieved a population life expectancy which was only six years lower than that achieved in the USA (Dasgupta 1993, pp.92–93).[1] Further, as argued in chapter two, significant welfare improvements, which also provide major health benefits can be provided to vulnerable persons simply by ending unjust, harmful behaviours on the part of wealthy nations.[2]

The basic right to health care does impose extensive obligations on duty bearers. However, the importance of health care for the enjoyment of other rights means that some costs at least are necessary in order to adequately guarantee the other basic rights. As such, the cost of providing basic health care rights can, at least partly, be recognised as part of the cost of guaranteeing other important rights. Further, in the following sections I provide a more detailed argument for the economic and epidemiological benefits of universal provision of basic health care.

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[1] See also, (Hotez et al. 2009).

[2] As noted, this is the focus of much of Pogge's argument in *World Poverty and Human Rights* (2008c, pp.118–122).

5.4a – The Epidemiological Argument

In this section I argue that there are good, self-interested and health focused reasons for providing at least certain kinds of health care to all persons. This claim can be loosely termed the 'epidemiological argument' for the provision of certain health care services.[1] I use this term as it draws attention to the significant health related benefits associated with responding to certain kinds of deprivation of health which accrue to all persons. Further, it also acknowledges the existence of the significant risks associated with failing to respond to such deprivations of health.

To make this argument I suggest three egoistic reasons for providing at least certain kinds of care to all persons. Firstly, doing so reduces the presence of infection in society, and thus reduces risk to all persons. Secondly, providing effective, appropriate health care can slow the evolution of antimicrobial resistance, impeding the development of more dangerous threats to health. Third, certain health promoting goods can only be provided to anyone if they are also provided to everyone, meaning that if the wealthy wish to benefit from a health promoting good, they must ensure it is available to all people. In addition to these points I also acknowledge that the 'epidemiological' argument does not apply to all health deprivation hazards, it is of limited utility as an argument for providing treatment for injuries for example.

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[1] I accept that epidemiology is a term not applicable to harms caused by natural disasters or dangerous driving. Despite this, the term is apt since it refers to the practice of providing care to others in order to protect oneself, an endeavour most obvious in the process of delivering care to prevent outbreaks of infectious disease, which gives the argument its name.

However, even providing health care which responds only to those threats to which the epidemiological argument applies would offer significant benefits to vulnerable people.

The first benefit which can be derived from the provision of accessible health care to all is that it reduces the presence of infectious hazards within a community which pose a risk to all persons (Battin et al. 2009, p.12). As noted in chapter three, effective long term protection from many types of infectious disease requires that as many people as possible are able to access vaccination and treatment services, and actually make use of such services (Vitek & Wharton 1998; Selgelid 2009, pp.432–433). Where treatment is less accessible, or where treatment is not used (Etkind et al. 1992; L. B. Reichman 1996; Salmon et al. 2009), more people are likely to be affected by vaccine preventable infectious disease, the effects are likely to be worse (Serpa et al. 2009; Yilmaz & Raynaud 2013), and the presence of the disease will persist over longer periods of time. Limiting the accessibility of health care services thereby contributes to the prevalence of infectious disease by increasing both the likelihood that more people will become infected, and the durations of those infections (Farmer 1999, pp.230–231). Creating such ‘reservoirs of infection’ (Battin et al. 2009, p.12) thereby increases the risk of infection for third parties, including those who are able to afford private medical treatment personally. As such, to refuse to provide treatment for, or protection against, certain deprivations of health to the poor is to actively select for increased risks even for the wealthy.

Related to this point, the second benefit of universal health care provision is that treatment services which only offer limited access to the poor are likely to contribute to the evolution of antimicrobial resistance in infectious diseases, creating more dangerous threats to health over time (Reichman 1997; Farmer 1999, pp.230–231; Feikin et al. 2000). For these reasons the provision of certain types of health care service to those who cannot afford them for themselves contributes to health care protection for everyone. That is, while some people may be able to afford excellent treatment and prevention services which provide good protection against health deprivations, it remains in their interests to provide at least some health care services to the poor because doing so reduces their own vulnerability to infectious disease in the short, medium, and long term.

Third, there are certain kinds of non-medical health care service which convey group benefits, but which can only be enjoyed by individuals if it is made available to all persons. For example, enforcement of traffic laws can reduce the risk of physical injuries by reducing the frequency of traffic collisions (Blincoe et al. 2002, p.1; Australian Transport Council & Australian Transport Safety Bureau 2006, p.1). However, it is not possible to provide this protection to a minority group in society without also providing it to all members of that society. Similarly, reducing pollution can reduce risk of non-infectious respiratory diseases like asthma (Peden 2005), and reducing environmental degradation also reduces risk of larger scale natural disasters

(Moellendorf 2009, pp.111, 114; McMichael et al. 1996, p.6).[1] As group goods, each of the interventions mentioned can only be provided to anyone if they are to be provided to everyone, as discussed in the previous section, and elsewhere (Widdows & West-Oram 2013a). Correlatively, it is not possible to exclude people from enjoying safer roads or a cleaner environment, even if the cost of provision is met by only a small minority of people. Further, the benefits derived from these kinds of intervention are such that everyone has reason to value them, and even those who dispute the right to health care have reason to contribute to the provision of safe roads and a clean environment, because by doing so they will gain protection from significant threats to health.

Finally, it should be noted that there are many health deprivation hazards to which the epidemiological argument does not apply; providing treatment to a person infected with tuberculosis reduces risk to others in a way that treating a broken limb does not for example (Ahmad & Morgan 2000, p.157). Consequently, arguing for the universal provision of basic health care services on epidemiological grounds cannot provide a justification for the provision of certain kinds of health care. However, even if only those health care services to which the epidemiological argument applies were delivered to all persons, the benefit to the vulnerable would be significant. Partly, this is because of the inherent value in protection from at least some infectious

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[1] The herd immunity derived from the effective implementation of vaccination programmes is another benefit which can only be enjoyed collectively, as discussed earlier in the chapter (Anderson & May 1985; Fine 1993; John & Samuel 2000).

disease. However, in addition, protection from disease has instrumental economic value (in addition to the instrumental value of being able to enjoy other rights) in that it removes one barrier to being able to provide other health care and subsistence goods for oneself (Viravaidya et al. 1996, pp.10–12; Selgelid 2009, p.432). That is, by removing the barriers to subsistence imposed by one category of health deprivation hazard, it is made easier for those affected to remove other barriers, as I discuss in the following section.

In this section I argued that the provision of certain types of health care to everyone for some health deprivation hazards is an effective method of reducing risk, even for individuals who can afford excellent private medical care. I described this claim as the ‘epidemiological argument’ for the provision of health care. However, the epidemiological argument does not apply to all cases in which the basic right to health care may apply, such as the occurrence of injury in distant countries. Further, some people may be willing to accept increased medical risk to themselves in order to avoid the cost of providing care to others.[1] Therefore, the epidemiological argument does not answer all self-interested objections to the provision of health care to all persons. However, an economic argument can also be proposed, which focuses not on the risks of physical harm, but on the economic consequences of failing to provide basic health care for all.

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[1] I reject this position as unjustifiable elsewhere (West-Oram 2013).

5.4b – The Economic Argument

In the previous section I argued that the risks associated with failing to provide at least some basic health care services to all persons provide a compelling reason to ensure the accessibility of certain health care services. However, I also noted that while the epidemiological argument can provide justification for the provision of some health care services, it does not apply in all cases, and cannot be used to justify the provision of health care when there is no benefit to third parties. In response to this issue, in this section I offer two economic arguments for rejecting claims that there are no obligations to provide health care to other persons; first, I argue that even if duties to others are rejected, ensuring universal access to health care is cheaper for all persons than treating health care as a commodity. Second, I argue that as well as minimising personal financial costs, the universal provision of even basic health care services can generate economic benefits for all persons.

First, the claim that there are no health care obligations to other persons is at least partly based on the idea that providing health care is a personal responsibility or choice, and that failure to adequately protect oneself is a personal matter (Johnson 2011; Lavender 2011; Romney For President, Inc. 2012). Conversely, the provision of publicly accessible health care services which are funded through proportional taxation implies recognition of an obligation to provide care to those unable to afford health care privately. Such systems represent one way in which wealthier agents are able to support their poorer counterparts by subsidising the cost of needed care. Health care systems which are publicly funded and free at the point of delivery are therefore antithetical to those who deny obligations to aid. However, public funding of health care provision through proportional taxation is more cost effective and provides better outcomes than systems which rely on the private purchase of health care services (Schoen et al. 2010; Schoen et al. 2011; Anderson et al. 2012; Davis et al. 2014).

A study published in 2011 which compared eleven high income countries[1] has shown that health care systems which are publicly funded and which feature greater centralised control are typically significantly more cost effective, and more accessible than systems which rely on the private purchase of insurance (Schoen et al. 2011, p.2439).[2] For example, 27% of American respondents to the survey reported that they had had difficulty meeting the cost of health care in the past year, compared to only 1% of British respondents (Schoen et al. 2011, p.2439). In addition, 42% of American respondents had avoided seeking medical care in the last year because of cost, the highest percentage of any country in the survey (Schoen et al. 2011, pp.2439–2440). It should also be noted that American respondents were more likely than respondents from other countries to face financial barriers to access even when insured (Schoen et al. 2010, p.2323). In a follow up study, the United Kingdom, the National Health Service of which is entirely publicly funded, was ranked

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[1] The countries in the study were Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States.

[2] See also, (Anderson et al. 2012).

most highly in eight of the eleven measures considered by the study, and was ranked first of all the countries evaluated overall (Davis et al. 2014, p.7).[1] In contrast, the United States of America, where health care is provided through the purchase of private health insurance in an open market, was ranked last overall (Davis et al. 2014, p.7).

An earlier, unrelated study had also found that even Americans with health insurance were not guaranteed access to care (Himmelstein & Woolhandler 1995). This study found that of those unable to access care, three-quarters were insured. Further, 65.1% of the total number of people unable to access care reported high costs or lack of insurance as the main barrier to access (Himmelstein & Woolhandler 1995, p.341). A further study has also shown that despite increases in family income between 1999 and 2009, health care costs for the 'average American family' have dramatically increased leaving them worse off in real terms (Auerbach & Kellermann 2011, p.1630).[2]

The poor cost efficiency of private systems of health care provision is also demonstrated by differences in national spending on health care, and the health outcomes which are achieved by different systems of health care provision. As a percentage of its GDP the USA spends far more than other

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[1] The same eleven countries were surveyed again (Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States).

[2] This study found that while the average family enjoyed a reduction in monthly health care costs of $95, this saving was artificial as taxes collected were insufficient to cover the cost of federal health care spending. Therefore, the $95 'saving' is in reality only contributing to the deficit costs of the United States, rather than providing a real saving. Had taxes matched spending, the family would actually find themselves $295 worse off (Auerbach & Kellermann 2011, pp.1630–1632).

Organization for Economic Cooperation and Development (OECD) countries on health care provision. In 2001 the OECD average was 8.1% of GDP (the United Kingdom spent 7.6% of GDP on health care) whereas the USA spent 13.9% of GDP on health care (Reinhardt et al. 2004, p.11). In addition, it is not clear that increased spending correlates with better health outcomes, especially at the level of general population health. For example, a recent study of ‘major developed countries’[1] (Pritchard & Hickish 2011, p.1788) which compared increases in cancer related health care spending with reductions in cancer mortality rates found that the British NHS achieved the best ratio of spending to cancer mortality reduction of the countries surveyed despite a lower than average increase in spending (Pritchard & Hickish 2011, p.1791).

The results of these studies indicate that private systems of health care provision, which deny the existence of obligations to other persons, are more expensive (Reinhardt et al. 2004), less efficient (Anderson et al. 2012), and offer lower quality of care (Schoen et al. 2010; Davis et al. 2014) than systems which assert obligations to provide care to all persons. Further, public systems of health care can have better health outcomes for less cost (Pritchard & Hickish 2011). Therefore, there are good reasons, in terms of reduced costs, improved accessibility, and higher quality of care for endorsing systems of health care provision which provide aid to all persons. In addition, these benefits should be seen as valuable even by those who are

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[1] Australia, Canada, England and Wales, France, Germany, Italy, Japan, Netherlands, Spain and the United States.

able to personally afford private health care, and who are ideologically opposed to the idea of obligations to provide health care to all persons.

The argument given above for the economic benefits of universal basic health care provision emphasised the personal financial savings which are generated by health care systems which assert obligations to other persons and which fund health care provision publicly. The argument I present below instead focuses on the general economic advantages[1] to be gained by investing in the universal provision of basic health care services.

The economic costs of deprivations of health are not borne solely by their victims, though victims may often face significant financial burdens where health care provision is not publicly available (Viravaidya et al. 1996, p.11). Deprivations of health can limit the ability of the deprived person to work in the short, medium and long term, and can impose significant costs on society as a whole because of this lost productivity. For example, the cost to the economy of motor vehicle collisions in the USA was $230.6 billion in the year 2000, equal to approximately 2.3% of U.S. GDP for that year (Blincoe et al. 2002, p.1).[2] Further, the economic costs per fatality exceeded $977,000, over 80% of which was 'attributable to lost workplace and household productivity' (Blincoe et al. 2002, p.1). Australia has also reported proportionally similar economic costs of motor vehicle crashes which were

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[1] As opposed to personal financial advantages.

[2] Improvements in traffic safety may not seem to obviously qualify as health care services, but as I have argued throughout this thesis, what counts as a health care service should not be limited to the obviously medical, and improvements in traffic safety do have significant public health advantages.

recently estimated at $18 billion annually (Australian Transport Council & Australian Transport Safety Bureau 2006, p.1). While, better enforcement of traffic law and improvements to transport infrastructure will not be able to completely remove these costs, both reports note the significant economic benefits to be gained by improvements to, or increased use of, existing safety systems (Blincoe et al. 2002, p.3; Australian Transport Council & Australian Transport Safety Bureau 2006, p.19).[1]

Deprivations of health can also have far greater implications when they occur in poorer countries and can dramatically hinder economic development. For example, between 1965 and 1990 countries in which malaria was prevalent experienced average GDP growth of 0.4% per year, compared to an average of 2.3% per year for countries outside of malarial zones (Sachs & Malaney 2002, p.681). Similarly, in Nigeria, guinea worm disease (dracunculiasis) contributed to morbidity in 2.5 million people in 1987, '[C]ost benefit analyses revealed that the disease was the chief impediment to increasing rice production' – leading to a loss of '$50 million in forgone revenue' (Price-Smith 2002, p.99). Conversely, public spending in the promotion of health can have significant economic benefits. For example, malaria eradication in Sri Lanka between 1947 and 1977 increased national income by 9% in 1977. The cost of containment of the disease was $52 million with a cumulative

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[1] Correlatively, reductions in public spending on tuberculosis control in New York City in between 1968 and 1978 which saved approximately $200 million contributed to a vast increase in incidences of the disease. In addition, a large proportion of infections were caused by drug resistant strains of the disease, contributing to costs of over $1 billion spent on treatment and control (Farmer 1999, pp.230–232). Preventative public health spending by states can have major economic benefits for society as a whole, as well as for individual persons.

gain of $7.6 billion over the same time period (Price-Smith 2002, p.98). Prevalent disease can also inhibit the profitability of private corporations. A report published by UNAIDS in 2003 noted that employee absenteeism due to HIV/AIDS in East Africa could account for between 25-54% of company costs (UNAIDS 2003, p.7). In comparison, the report suggested that the provision of cheap or free antiretroviral therapy to employees could enhance employee retention and decrease absences due to illness, thereby reducing costs to employers (UNAIDS 2003, pp.19–20).[1]

I do not wish to suggest that economic arguments can be used to justify the provision of aid to all persons in all cases. Sometimes the provision of treatment will not be cost-effective, or will impose greater costs on society than refusing treatment.[2] However, in some contexts, increasing spending on health protecting services for those unable to afford them for themselves will generate significant economic benefits in terms of increased productivity, economic development, and the avoidance of greater costs long term. Therefore, in at least some cases, the provision of health protecting interventions and treatment can actually be in the interests of those who would deny obligations to aid, because doing so will either generate economic benefits in terms of employee productivity, or reduce the extent of inevitable future costs.

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[1] As noted above, the persistence of endemic disease and poverty increases the risk of international transmission of infectious disease (Battin et al. 2009, p.34). It also reduces the number of potential employees for businesses trading in poor countries (UNAIDS 2003, pp.19–20).

[2] I discussed the application of analysis of the opportunity costs of providing or not providing health care in different scenarios in the previous chapter.

In this section I first argued that the costs of guaranteeing a basic right to health care to all persons will not necessarily be prohibitive. Second, I outlined two non-ethical reasons for providing basic health care to other people. The epidemiological argument focuses on the risk-reducing benefits of providing prophylactic care and treatment for victims of certain kinds of health deprivation in order to limit personal risk for everyone. The economic argument focused instead on the negative financial consequences of failing to prevent or treat harm, and on the increased cost-effectiveness for all persons (including the wealthy) of publicly funding health care for all. In the increasingly interconnected world in which we live, these arguments apply just as well to the provision of health care services to citizens of other countries as they do to providing care to compatriots. Disease can linger in economically, ideologically, or geographically isolated locations only to re-emerge in new regions as a result of increased tourism and trade (Ewald 1994, pp.204–205; Battin et al. 2009, p.34; Salmon et al. 2009). Similarly, the presence of disease can hinder economic development and reduce productivity, limiting the financial benefits which can be derived from regions prone to endemic disease. I do not claim to have presented a full argument here for the egoistic reasons to provide health care to all, but in highlighting these examples, I have attempted to demonstrate that even if the existence of moral duties is denied, self-interest should motivate the provision of at least some health care services to those unable to afford them personally.

In the following section I provide an overview of my goals in this chapter.

5.5 – Summary

In this chapter, I concentrated on four main categories of objection to the basic right to health care; the first focused on the alleged unsuitability of human rights doctrine as a theory of global justice, and examined cultural criticisms of my argument. The second category focused on the difficulty of reconciling the importance of group goods with an approach to justice which is heavily focused on the entitlements of individuals. The third objection to the basic right to health care discussed in this chapter is that a distinct basic right to health care is unnecessary because the health care demands of the basic rights model can be accommodated within the basic right to subsistence. Finally, I addressed the objection that there are no obligations to other persons, and that the basic right to health care has no normative force.

In responding to these objections I argued that for theoretical and practical reasons, thinking in terms of a basic right to health care is an effective way of theorising about global health care justice. I argued that even if rights talk is accepted to be generally incompatible with certain cultural settings, the unique features of the basic right to health care mean that it is less vulnerable to objections based on cultural grounds. Second, I argued that while the basic right to health care does focus on promoting the health of individuals, achieving this goal will require it to impose restrictions on individual entitlements to certain goods in order to ensure their sustainability. Third, I argued that differentiating the basic rights to health care and to subsistence clarifies the requirements of the basic right to health care, and highlights the importance of the right. Finally, I argued that there are good, self-interested reasons for fulfilling the basic right to health care which should motivate even those who deny the existence of duties to other people.

It is not possible to provide responses to every objection to my argument in this chapter, or to provide complete defences against the objections which I do discuss. However, the objections which I do consider represent the most significant and most philosophically interesting objections to my argument for the basic right to health care. Further, the defences I offer against these objections, while incomplete, do provide an overview or template for more comprehensive responses to the objections discussed.

In the following, final, chapter I summarise the general arguments of this thesis.

CHAPTER SIX

CONCLUSION

In this final chapter, I provide an overview of the arguments presented in this thesis. To do so, I first set out the goals of the thesis and summarise the structure of my argument for the basic right to health care. Second, I provide an overview of my discussions and arguments in each of the preceding chapters and show how each of the three key goals of the thesis have been achieved. Finally, I restate the claims of the thesis and summarise my arguments for the importance of the basic right to health care.

6.1 – Goals and Approach

I have three main goals in this thesis; first, to argue for the importance of the basic right to health care; second, to define the requirements of the right; and third, to propose ways in which the right can be fulfilled in terms of Shue's triumvirate of duties. In the following section I describe in detail how each of the goals stated here have been fulfilled by the specific arguments presented in each chapter. First however, I briefly summarise the structure of the thesis.

First, in chapter one I argued that access to health care is necessary requirement of the enjoyment of all other rights and that as such it qualifies as what Henry Shue described as the substance of a 'basic right' (1996, p.18). To make this argument I examined Shue's basic rights model and argued that it provides an effective way of theorising about global justice. Adopting

Shue's model, I argued that a right to health care is necessary to guarantee right holders the ability to enjoy their rights as rights, rather than as contingent 'privileges, discretions, [or] indulgences' (Shue 1996, p.81). Second, my argument in chapters two, three, and four focused on the way in which Shue's triumvirate of duties, to avoid depriving, protect from deprivation, and aid the deprived, could be applied to a basic right to health care. In doing so I argued that deprivations of health can make it impossible for right holders to enjoy any of their rights, and proposed a range of practical methods by which such deprivations could be avoided, prevented, or cured. Finally, in the previous chapter I examined four categories of objection to my argument for a basic right to health care and provided brief responses to each.

6.2 – Chapter One: Introducing the Basic Rights Model and Arguing for the Basic Right to Health Care

In chapter one I argued for the utility of the basic rights model as a method of theorising about global health care justice and the welfare and entitlements of right holders. I also argued for the importance of access to health care for the enjoyment of all other rights, and that health care is of sufficient importance to qualify as what Shue describes as the substance of a basic right. In doing so, I provided an outline of Shue's model of basic rights and their corresponding duties and noted the utility of certain important features of the model. In this section I provide a brief overview of my argument in chapter one and demonstrate how that argument supports the goals of this thesis.

Shue argues that the purpose of moral rights is to provide right holders with protection against harms that they would otherwise be powerless to prevent or avoid (1996, p.18). According to Shue, all moral rights provide '(1) the rational basis for a justified demand (2) that the actual enjoyment of a substance be (3) socially guaranteed against standard threats' (1996, p.13). Basic rights are those rights which are required for the enjoyment of all other rights. They are the prerequisites, or necessary conditions of enjoyment of all rights and thus fulfil what I described in chapter one as the necessity criterion (1996, p.19). A basic right therefore fulfils each of the three aspects of the definition of moral rights described by Shue, and is fundamentally necessary for the enjoyment of all other rights.

Shue states that his primary purpose in *Basic Rights* is to 'rescue from systematic neglect within wealthy North Atlantic nations a kind of right that…deserves as much priority as any right: rights to subsistence' (1996, p.65). In pursuing this goal, Shue argues that subsistence rights are just as important for the enjoyment of other rights and any decent life, as more frequently asserted rights to security (1996, pp.20–29). In doing so he argues that deprivations of subsistence goods can cause harms to right holders which are just as severe as deprivations of security rights. Further, being denied rights to security, subsistence, or liberty can make it impossible for right holders to enjoy their other rights, because such enjoyment depends upon enjoyment of the basic rights. Therefore, he argues that subsistence should be acknowledged to have same status as security and that both should be recognised, along with liberty, as the substances of basic rights.

My first goal in chapter one, and indeed in this thesis generally, was to demonstrate the importance of access to health care for the enjoyment of any other rights, and to thus argue for its status as a distinct basic right. Following Shue's argument mentioned above, I claimed in chapter one that deprivations of health can also make it impossible for right holders to enjoy the substances of all their other rights. I also argued that while Shue does mention some health care services in his discussion of the basic right to subsistence (1996, p.23), he does not consider them in detail. Therefore, I argued that access to health care is necessary for the enjoyment of all other rights, and that it qualifies as a basic right in the same manner as the basic rights to subsistence, security, and liberty.

My second goal in chapter one was to demonstrate the utility of the basic rights model. To do so, I argued that the model provides significant theoretical clarity and focuses on actually enabling right holders to achieve at least a minimal standard of quality of life. In addition, the basic rights model emphasises the existence of demanding duties, and states that both individual and institutional agents can have responsibilities towards right holders. In doing so, it provides a complex, detailed, and applicable account of the requirements of the basic rights, which I argued provides valuable clarity along three important vectors.[1] The breadth and specificity of the basic rights model is also valuably precise about the way in which each of the basic rights

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[1] I also expanded on this argument in chapter five, when I argued that the basic right to health care was even less vulnerable to objections based on cultural incompatibility than the rights Shue proposes.

is to be fulfilled through the triumvirate of duties, and allows for the assignation of specific responsibilities to a wide range of duty bearers. That is, as I argued in chapters two, three and four, the triumvirate of duties is broad enough in scope to allow for both individuals and institutions to have duties to right holders (Shue 1996, p.60). In the following sections I discuss the three duties in more detail. In each chapter I discussed a range of potential health deprivation hazards and proposed frameworks of practical requirements of each specific duty. In doing so, I also argued for the importance of a right to health care for the enjoyment of all other rights.

6.3 – Chapter Two: The Duty to Avoid Depriving and the Basic Right to Health Care

In chapter two I discussed the first of Shue's three duties and noted that while it is phrased as a negative duty to 'avoid depriving', it actually requires significant 'positive' action in order that it be fulfilled. In doing so, I provided additional examples of the ways in which deprivations of health can cause harm to right holders, and argued for the existence of extensive obligations owed to right holders under the duty to avoid depriving. I discussed this duty with reference to the TRIPS regime and its role in limiting the accessibility of essential medicines, restricting innovation, and reducing freedoms to produce generic medicines for consumption by the vulnerable poor. I also noted a number of other global economic and political practices which impose similar deprivations on right holders globally. Fulfilment of this duty, I argued, requires three types of behaviour; non-malevolence, conscientiousness, and impartiality. It is the third of these requirements to which the TRIPS regime fails to adhere.

Fulfilment of the duty to avoid depriving requires more than mere restraint in the face of opportunities to cause harm. In the context of a basic right to health care, I argued that the duty demands that duty bearers not deliberately cause harm, consider the consequences of their actions, act to minimise risk to third parties, and ensure that the rejection of the basic rights of others is not accepted as a valid cost of fulfilling the interests of preferred agents. While it is tempting to think of the duty as requiring nothing more than non-malevolence, in reality, the significantly harmful consequences of seemingly neutral economic practice demonstrate the importance of more demanding obligations from duty bearers. While this duty will not generate significant health care provision, in terms of medical services or protective social infrastructures, fulfilment of the duty is essential to the right to health care because it will remove, or at least reduce the risks to right holders of agent directed deprivations of health and minimise the impact of systems which currently restrict the accessibility of essential goods. As such, the role of the duty to avoid depriving as it relates to the basic right to health care is to prohibit, and thus remove, those actions, behaviours, and systems which either directly deprive or make it impossible for right holders to access the goods to which they are entitled.

6.4 – Chapter Three: The Duty to Protect from Deprivation and the Basic Right to Health Care

In chapter three I examined the requirements of the duty to protect from deprivation in the health care context with reference to the global problem of infectious disease. I argued that effective fulfilment of the duty would require three types of action or behaviour; firstly, the provision of social-infrastructural systems designed to limit the spread of infection. Secondly, the provision of medical interventions to treat infected persons to prevent the spread of contagion and thus protect third parties. Finally, the duty has a behavioural requirement which obliges duty bearers to participate in the provision of protective health care services like vaccination programmes in order to ensure their effectiveness.

While the specific interventions I discuss in the chapter are applicable only to the prevention of infectious disease, the categories of intervention to which they belong have far wider applicability. For example, the social-infrastructural category of interventions might include the provision of effective road safety measures as a means of preventing injuries caused by traffic collisions. In this way, it is possible to respond to the risks of unsafe roads by reducing speed limits, changing the physical construction of the road, or enforcing better driving through police presence, an analogue of ‘treating to protect’. Similarly, the behavioural requirement to participate in vaccination programmes can be seen as analogous to demands to pay one’s fair share of the tax burden to fund, and thereby contribute to the cost of delivering effective public programmes for the protection of health.

In discussing the requirements of the duty to protect from deprivation I argued that Shue’s original statement of the duty did not obviously apply to deprivation hazards which are unrelated to human action, such as infectious disease and natural disasters. Therefore, I proposed an expansion to Shue’s original statement of the duty which more explicitly refers to the need to protect right holders from agent independent deprivation hazards. The expanded formulation of the duty to protect suggested in chapter three is very similar to Shue’s original formulation, but more explicitly refers to a broader set of potential deprivations. However, as I argued in the chapter, this need not commit duty bearers to excessive obligations, since the protections offered need only offer reasonable, and not infallible, guarantees of protection against ‘standard threats’ to health. Further, many of the protections discussed in the chapter are extremely cost effective, and may confer additional benefits in terms of costs avoided as a result of effective prevention or avoidance, as opposed to treatment, of difficult or expensive to treat health deprivations.

6.5 – Chapter Four: The Duty to Aid the Deprived: Five Criteria for Prioritising Potential Health Care Responses

In chapter four I discussed the duty to aid the deprived and noted that while the duty may often be the most important, effective fulfilment of the basic right to health care (or of the other basic rights) may require that fulfilment of the other basic rights be prioritised. This is because failures of the pro-active duties may lead to 'Sisyphean duties to aid' and thus make effective fulfilment of any duty impossible (Shue 1980, p.63). In this chapter I proposed a set of five criteria with which to analyse deprivation scenarios in which aid might be owed or needed. These criteria can be used to distinguish between competing cases and assign priority to the most important in order to facilitate the most just and effective distribution of limited resources. In addition, the criteria discussed in chapter four can used to set both upper and lower limits on the duty to aid and can thus ensure that the duty does not commit duty bearers to too much, and that aid is delivered as effectively as possible by the agents most suited to the task. In this way, these criteria also provide the means to assign responsibility for fulfilling the duty to the appropriate agents. Importantly, the five criteria are also relevant to the duty to protect from deprivation, and fulfil similar roles for both the duty to aid and the duty to protect, as was also discussed in chapter four.

6.6 – The Triumvirate of Duties and The Basic Right to Health Care

The goal of the three duties suggested by Shue is to respond to the existence of hazards which can deprive right holders of the ability to enjoy their other rights and a minimally decent life, to ensure that the risks associated with such hazards are prevented or minimised, and that any harms that do occur are ameliorated as far as is reasonably possible. In the context of the basic right to health care, these duties are intended to respond to deprivations which are caused by both agent behaviour, and by agent independent deprivation hazards, as discussed in chapter three.

It has not been possible in this thesis to provide a full account of every possible intervention that is required by the three duties as they correlate to the basic right to health care. However, in outlining the requirements of the duty with reference to a number of key examples, it has been possible to provide an outline of the kinds of obligations that the duties impose on duty bearers. In addition, the analysis of the three duties provided an opportunity to demonstrate the breadth of interventions required in order to guarantee the basic right to health care, and to provide a model for establishing just limits on what those duties oblige duty bearers to do (as discussed in chapter four). Finally, by demonstrating how the duties function in relation to the basic right to health care I have attempted to show how deprivations of health can make enjoyment of other rights impossible, by examining key examples of health deprivations. Further, I have shown how the duties provide a sound theoretical framework upon which to build effective practical responses to these deprivations. In doing so, I argued that the duties are easily applicable to the basic right to health care, and that the right can therefore be accommodated by the basic rights model. This is because the right itself fulfils the necessity criterion, as discussed in chapter one, and because the triumvirate of duties can protect health effectively without imposing unreasonable demands on duty bearers, as discussed in chapters two, three, and four.

6.7 – Chapter Five: Responding to Objections

Having argued for the utility of the basic rights model, and for the importance of rights to health care in chapters one to four, in chapter five I considered four objections to my argument for a basic right to health care; first, that rights are an inappropriate justice paradigm in ‘non-western’ cultural contexts in which the welfare of groups is prioritised over that of individuals. Second, that the individualistic focus of rights makes a right based entitlement to health care unable to account for the realities of preserving group goods effectively. Third, that the health care requirements of the basic rights model are accommodated within the basic right to subsistence, making a distinct basic right to health care superfluous. Fourth, that there are no obligations to other persons, and that as such, the basic right to health care cannot require duty bearers to do anything for other right holders.

My goal in addressing these objections was to highlight the validity and utility of the basic rights model, and the basic right to health care in particular, as a means of theorising about global health care justice. To illustrate, I noted that while Shue does acknowledge some health care services in the basic right to subsistence, he does not examine the health care requirements of the basic rights model in depth. Further, I argued that the complexity and importance of the basic right to health care merits discussion of it distinct from the basic right to subsistence, if only for purposes of theoretical clarity. I also argued that the unique features of the basic right to health care make this right specifically even more resilient in the face of these objections. For example, I argued that even if duties to others were rejected, there are significant economic and epidemiological advantages to be gained from providing care to all persons. Similarly, I argued that because the provision of health care is often a fundamentally public or socially focused project, as discussed in chapters three and four, a right to health care is compatible even with the inaccurate and stereotyped description of non-western cultures proposed by opponents to rights.[1]

In the following section I conclude this thesis by summarising its goals and arguments.

6.8 – Conclusion: Justifying the Basic Right to Health Care

As noted at the start of this chapter, I have had three goals in this thesis; first, to argue for the importance of the basic right to health care; second, to define the requirements of the right; and third, to propose ways in which the right can be fulfilled in terms of Shue's triumvirate of duties. In pursuing these goals I have argued that deprivations of health can make enjoyment of any rights impossible, in the same way as violations of physical security, or deprivations of the means of subsistence. Therefore, I argued that guaranteed access to health care is equally as important to the enjoyment of all other rights, as guaranteed access to subsistence or security goods. Consequently, access to health care fulfils what I described as the necessity criterion, and

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[1] I also argued that the description of 'non-western' values which are presented by critics of rights are frequently inaccurate, and arguably racist (Diokno 1978 quoted in Shue 1996, p.66).

therefore qualifies as the substance of a basic right in the same manner as those basic rights originally defined by Shue.

In making this argument I examined the specific aspects of Shue's triumvirate of duties, and attempted to demonstrate how each could be applied to a putative basic right to health care. My goal in doing so was first to show the compatibility of a major feature of Shue's basic rights model with my proposed right. Second, to highlight the effect that deprivations of health can have on the ability of right holders to enjoy their rights. Third, to propose a framework of health care provision intended to protect right holders from the consequences of standard threats to health.

I have argued that the basic right to health care must guarantee entitlements to those goods, services and behaviours which provide reasonable guarantees of protection against the standard threats to health. While such a guarantee may provide significantly more than what is currently enjoyed by much of the world's population, for example by guaranteeing all persons access to basic essential medicines, or to social institutions which provide protection against a range of deprivation hazards, it does not mean that right holders have a right to never get seriously ill or die, as noted by Shue. Instead, the basic right to health care entitles right holders only to reasonable (and thus limited) guarantees of access to those health care goods which are necessary in order to avoid deprivations which will make enjoyment of all other rights impossible.

Without access to health care, human beings are vulnerable to a multitude of threats to their wellbeing, any one of which may deprive them of their ability to be free, nourished, or secure at any time. As such, I have argued that the basic right to health care must be recognised as a prerequisite of living any decent human life, and more must be done to guarantee it. This thesis has been an attempt to provide a theoretical, and at times practical, argument for why this is so, and to contribute to ensuring that all persons have access to at least basic health care services.

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