

THREE AND A HALF ARGUMENTS FOR GLOBAL SOCIAL PROTECTION FOR HEALTH (A PERSONAL STORY)

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Abstract

In this paper, I will try to give an overview of my main arguments for global social protection, and at the same time relate those arguments to some important events in my personal life. This is not what academics are expected to do, but this is not a purely academic publication.

My first argument is purely humanitarian – it is about saving lives. In 2000, in Mozambique, the Médecins Sans Frontières team I was leading and the Ministry of Health (MoH) were not able to save the lives of children with AIDS, because of an ideological belief: the belief that open-ended solidarity across borders – comparable to the open-ended solidarity we practice within countries – is wrong, that states must be or become financially autonomous, and that health-promoting efforts should therefore not cost more than what a country can afford without becoming dependent on assistance. This belief still kills millions of people every year. If global social protection for health, based on redistribution of income that is as reliable as it is within countries, would replace ‘development assistance’ as we know it, those lives could be saved.

My second argument is about human rights, about the right to health in particular. The inter-

national treaties may not as clear as they should be, and they may focus too much on national responsibility, which results in the right to health being quite different depending on the country one lives in. But they also conform that health is a human right; that every human being should have access to water, food, and essential health care; and that this a responsibility of humanity towards humanity. If access to water, food, and essential health care were not a responsibility of humanity towards humanity, health would not be a human right, but a privilege, for people born in the ‘right’ countries. This became the core argument of my doctoral thesis.

My next argument is about justice – it is not fundamentally different from the argument about the right to health, and therefore it only counts as half. Having appointed me as a ‘Global Justice Fellow’ at Yale, Thomas Pogge challenged me to explore why health is a human right, regardless to the treaties, as a matter of justice. My first answer is that human rights are translations of a pre-historical natural sense of justice, which demanded that members of a tribe acted as partners worthy of cooperation, and allowed each other to be partners – ‘to allow’ understood passively, but also actively, as in providing an allowance. Supporting each other in being or becoming healthy is an essential part of that, and it cannot be confined within country borders. My second answer is that within a free market mechanism, people may harm each other without knowing it, and without intention, because

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of ‘bad inequality’: the kind of inequality that allows the privileged to preserve their privileged positions. Social protection is a correction to that – a kind of insurance against unintended harm doing. As bad inequality works beyond borders, social protection should correct beyond borders too.

My third argument is about enlightened self-interest, from the perspective of the inhabitant of a high-income country. While I was looking for illustrations of increasing inequality between countries, what I found was increasing inequality within countries. Bad inequality is still working, not as much between countries – making rich countries richer and poor countries poorer – as it used to be, more between clans of people. The correction (social protection) is being eroded, because it is organised per country, and governments are obliged to adjust to the lower taxation and social protection standards of their neighbours. Social protection is succumbing to a kind of ‘tragedy of the commons’; it will take cooperation and harmonisation between countries to protect it within countries.

FIG. 1: MULTI-LAYERED GLOBAL SOCIAL PROTECTION



Conclusion: global social protection is the logical next step in the geographical expansion of mutual support systems – from tribes to cities, and from cities to countries, and from countries to the planet. From Doctors Without Borders to Social Protection Beyond Borders requires only an incremental change.

Introduction

The first time I heard about the idea of global social protection was in a rather dramatic brainstorming session about AIDS treatment in Mozambique in 2000. (Many years later, I found out that Abram de Swaan (1994) had suggested it even earlier.) It was the medical coordinator of our Doctors Without Borders or Médecins Sans Frontières (MSF) team, Piet Corijn, who came up with it. The idea has never left my mind since then; gradually it became the essence of my work.

Over the years, my reasons for promoting global social protection have evolved, expanded and matured. Most of them have been published, but not in a coherent way. This reader gives me an opportunity to briefly describe three and a half arguments, with references to the papers where they are published in greater detail.

To be clear, our proposal is not to create a global social protection scheme that would replace national schemes, only to add a layer. Social protection schemes are not monolithic blocs. For example, the average inhabitant of a member state of the European Union pays taxes and participates in social protection at the level of the city he or she lives in. In many European Union member states, there are taxes at sub-national levels (‘communities’ or ‘regions’ in Belgium; ‘Länder’ in Germany). The largest amount of tax is levied at the national level. Finally, all member states of the European Union contribute financially to the running of the European Union, which now contains some mutual social protection, albeit very modest (cf Holst: Implementing the So-

solidarity Principle through Financial Equalisation in this reader: 86-104). Within the United States of America, the situation is similar. Most people pay taxes at the municipal level, i. e. to the city in which they live, at county level, at the state level (e.g. as income tax or sales tax) and then at the federal level. The idea is not to replace all of that with a single global scheme but to add a relatively modest global layer, as the illustration expresses.

First argument: global social protection for health is a humanitarian duty

If there is a single moment that defined the rest of my life, it would be the moment when I was told that out of about 40 children we – the MSF team, supporting the MoH – were treating for malnutrition in Chokwe, Mozambique, one did not have AIDS. The town of Chokwe had been flooded in February 2000. People lost their homes, harvests and reserves, and relied on food distributions. These food distributions are never perfect; there always is a group of households that will be excluded because they are not duly registered, for example. And some of these excluded households will wait until one or more of their children are extremely malnourished before seeking medical assistance. That is why setting up a therapeutic feeding centre is one of the standard responses after disasters like floods. The children receive the specialised and fortified milk or dairy products they need, and the families are included in food distributions.

It also is one of the most rewarding interventions: a series of Lazarus-like ‘miracles’ can be expected. When the children arrive they are weak and silent, as if they are just waiting to die. A few weeks later, they can leave, smiling, cheerful and making all sorts of noise. And we had our series of ‘miracles’ in Chokwe. But not enough. Some children did not get better. They remained weak and silent, they had diarrhoea, and too many died. After a month or three, we

should have been able to close the centre: the households that had been excluded from the food distribution schemes should have been included by then, and the severely malnourished children should have recuperated. It did not make any sense. Then someone suggested that many of these children probably had AIDS, and that they were not malnourished because of the floods and the destroyed harvest, but because they had chronic diarrhoea – no matter how much they ate or drank, they would not recuperate.

Bringing up the hypothesis created a dilemma in itself. We had already discussed with the MoH the possibility of providing antiretroviral treatment and the answer was negative. The MoH did not want a foreign organisation to introduce a level of health care that it would not be able to continue or replicate, and in May 2000, we were still talking about a cost of US\$2,000 per person per year. (None of the antiretroviral medicines we needed were patent-protected in Mozambique, but even the generic versions were expensive; the offer from CIPLA – an Indian manufacturer of generic medicines – of a ‘cocktail’ at US\$1 per day came a year later.) And several ‘donors’ – I’ll explain later why they are not really donors – had made it clear they would not support AIDS treatment. If we tested children and they turned out to be HIV positive, we had nothing to offer them except some palliative care, so why would we test them at all? To satisfy our curiosity? But if they really had AIDS, they would have gotten it from their mothers – who could have been HIV positive without having developed full-blown AIDS yet – and some of their siblings would probably be HIV positive too. In that case, keeping the children and their mothers in a feeding centre seemed a cruel thing to do. Eventually, we agreed with the MoH to do ‘anonymous and unlinked’ tests, meaning that blood samples were taken without any code that could link them to the individual children they were taken from, so we would know how many children were HIV positive, but we would not know

which children were and which ones were not. (Anonymous and unlinked testing was pretty uncontroversial at that time; that is no longer the case, and for good reasons (Rennie et al. 2009).)

I was in the feeding centre when the results came back: only one of the children was not HIV positive. It was worse than expected, and we had already decided beforehand – after heated discussions – what our reaction would be: to send all children home to die as peacefully as possible. That was not a consensual decision; some of our team members wanted to keep the children there, and start making a video documentary with the title ‘World, Watch Them Die’, or something similar. The whole situation was absurd: a few months earlier, ‘donor’ representatives had been willing to hire helicopters for rescue operations at ridiculously expensive prices – US\$ 2,000 per hour or more. (If my memory is correct, one of our helicopters had come all the way from Bulgaria, because that was cheaper.) The very same people who had been willing to pay for that were now refusing to finance treatment at US\$ 2,000 per year, for the very same children they had saved at US\$ 2,000 per hour. I made a few phone calls to the MoH and to some of these ‘donor’ representatives, but they had not changed their minds. And then I watched mothers gathering their stuff, picking up their children, and going home silently – accepting their horrible fate.

It was not the first time I was confronted with this apparent contradiction between the ‘exuberance’ of relief and the stinginess of development assistance, provided by the same institutions. It is all about sustainability. If you want interventions to be sustainable, the countries where you want to have these interventions should be able to continue them with their own funding, at least in the long run – or so the theory goes. So you should not provide AIDS treatment in a country that has no real perspective of becoming wealthy enough, fast enough, to

take over the financing. In a crisis situation, however, you can ignore sustainability, because the crisis is temporary by definition. It does not matter that the Government of Mozambique cannot afford helicopters for rescue operations, because we are assuming – wrongly, in all probability – that the floods will not return. It is not an entirely senseless theory. If we want to avoid some countries becoming dependent on others, international assistance should be limited, in volume or in time.

That is the pleasant narrative about the contradiction between emergency relief and development assistance: the international community is aiming for countries’ autonomy, or emancipation. It is supported by many people and organizations; even people who strongly support increasing taxation as a matter of solidarity (between people within the same country) seem to object to long-term reliance on solidarity across national borders. For example, a senior political advisor at Christian Aid recently argued that the UK development secretary “must uphold UK aid spending while devising an exit strategy” and encourage developing countries to increase tax revenue to make aid redundant (Oyuela 2012). The less pleasant narrative is that international assistance is essentially charity, given by people and their representatives who feel that they do not ‘owe’ assistance to others who live in different countries. They are generous, but feel they should be allowed to end their generosity at any time.

In 2006, I wrote an article about this contradiction between emergency relief and development assistance (Ooms 2006). In Mozambique, in 2000, our pressing concern was not to examine or expose the contradiction, but to overcome it. Those were the circumstances in which our medical coordinator compared international assistance at the beginning of the 21st century with national assistance at the end of the 19th century: charitable, and therefore unreliable, and therefore not quite as useful as the same

amount of money could be, if given out of solidarity. And therefore, he argued, we should advocate in favour of global social protection.

We did not, I must admit; MSF did not take up advocacy for global social protection. We took the path we knew best; we called the epidemic of AIDS a global emergency and a humanitarian crisis, we called for relief, not for a better version of development assistance. It was a humanitarian crisis, we argued, and we got relief: for example, PEPFAR – the USA President’s Emergency Plan for AIDS Relief that was launched by the end of 2002 – had both ‘emergency’ and ‘relief’ in its name. And we should not be ashamed of millions of people living many years longer because of a massive and unprecedented relief response; this also means millions of children becoming orphans at an older age. But in hindsight, we could have ‘used’ the AIDS epidemic to illustrate the failure of development assistance and to call for a better version of it; one based on solidarity, not charity. Perhaps it is not too late.

To be sure, calling for global social protection instead of development assistance, as we know it is not essentially about the volume of transfers – although the volume of transfers would definitely increase if development assistance became global social protection. It is essentially about accepting that people owe support to each other, within countries and beyond the borders of countries, as a matter of solidarity, not charity. And this is not a semantic discussion: assistance that is reliable in the long run can do things that unreliable assistance cannot do. For example, if you are an MoH staff member of a low-income country and you receive a grant of US\$ 50,000, you could buy an ambulance or you could hire 50 nurses for a year. If you know the grant will be continued year after year, you will do better to hire 50 nurses, as they will save a lot more lives than an ambulance. But if you think the grant will not be repeated, you had better buy the ambulance, as it will not protest if it

is ‘fired’ next year. As explained in a shorter technical paper for this reader, unreliability of international assistance in the long run is probably the most underestimated problem of international assistance (cf. Ooms: Fiscal Space and the Importance of Long Term Reliability of International Co-financing in this reader: 135-139).

Second argument: global social protection for health is required to realise the human right to health

In 2001, the attitude of the international community towards the epidemic of HIV/AIDS changed quite dramatically. The most notorious manifestation of this change was the ‘Special Session on HIV/AIDS’ of the General Assembly of the United Nations, better known as UNGASS (United Nations General Assembly Special Session), which ushered in the so-called ‘Declaration of Commitment’ (United Nations General Assembly 2001). It called the HIV/AIDS epidemic “a global emergency”, and will be remembered for creating what became the Global Fund to fight AIDS, Tuberculosis and Malaria – or, as worded in the Declaration, for supporting “the establishment, on an urgent basis, of a global HIV/AIDS and health fund to finance an urgent and expanded response to the epidemic based on an integrated approach to prevention, care, support and treatment.” This was approved by the very same governments whose representatives had decided – 12 months earlier – to refuse treatment to the children with AIDS in Chokwe.

What had happened? In Mozambique, we were so happy about having a prospect of providing AIDS treatment that the question about the U-turn did not really matter. As the whole Declaration was engendering a sense of emergency, I could not help being worried, as I knew from experience that the international community’s attention for emergencies can be as intense as it is short-lived. What if, after a couple of years, the international community once again felt the

same way as it did 12 months before the Declaration? Would we stop treating people? Even then, our medical team members argued, a few years of treatment is better than no treatment at all.

Furthermore, AIDS was not our only concern. In the north of the country we were running a project that provided training to traditional birth attendants; the results were disappointing and many of our team felt that we should focus on hospital-based emergency obstetric care, which required ambulances and a communication system between health centres. This was expensive – indeed, it was considered too expensive for Mozambique – but not quite as expensive as AIDS treatment. And there was a general problem with user fees to be paid by people needing healthcare; we knew that they excluded many people. It was unimaginable that people would be asked to pay for AIDS treatment – even if the fees were only a fraction of the real cost, it would cause people to discontinue their treatment as soon as they felt better. In a nutshell, it did not seem fair that caesarean sections would not become available in places where AIDS treatment was, or that people would have to pay for malaria treatment but not for AIDS treatment.

The Declaration of Commitment on HIV/AIDS not only referred to the ‘global emergency’ but also contained several references to human rights, and the right to health in particular. For example, it mentioned that “access to medication in the context of pandemics such as HIV/AIDS is one of the fundamental elements to achieve progressively the full realisation of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” But surely, that was equally valid for other essential medicines as for emergency obstetric care. If taken seriously, it also required ensuring that nobody would be excluded from healthcare merely because they were unable to pay the user fees.

This reference to the right to health seemed promising, as it could provide a basis for reliable international assistance: not temporarily, as long as richer countries’ governments felt like it, but for as long as was necessary to realise the right to health. And it would apply to health in general, not to AIDS only. But there was something disingenuous about this statement, or so I felt. From my university days – I am a lawyer – I remembered that human rights define minimum levels of acceptable relationships between governments and the people under their jurisdiction; human rights are about what your government cannot do to you, or what it must do for you. They are not about what governments cannot do or should do for people living elsewhere, or so I remembered. And therefore it did not solve our problems in Mozambique, as it was too poor – and no person (or institution or government) can be obliged to do something it is unable to do.

So your human rights entitlements depend on what your government is able to do: if you happen to live in a wealthy country, your human rights entitlements are larger than they would be if you would live in a poorer country. That is what the reference to “achieve progressively the full realisation” in the Declaration of Commitment means. Surely, if you need AIDS treatment, it is an essential element of your right to health – your right to the enjoyment of the highest attainable standard of physical and mental health, as the International Covenant on Economic, Social and Cultural Rights defined it. But only if your government can afford it ...

When I was reading the Declaration of Commitment for the first time, I remember how I had disliked – as a student – this concept of progressive realization. If human rights are truly human rights, rights one has because of being a human being, they should not depend on the wealth of the country one lives in. Imagine that slavery would be illegal only in countries where the circumstances permitted the abolition of slavery. But if that is what the international treaties pres-

cribe, a United Nations' declaration should not suggest otherwise – or it should improve the treaties.

So I decided to refresh my memory. I vaguely remembered that the International Covenant on Economic, Social and Cultural Rights refers to international assistance as a means to hasten the progressive realisation, and I easily found it, in article 2(1) of the Covenant: “Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant.” (United Nations Commissioner on Human Rights 1966). But it was easier to find than to understand. Does it mean that states have obligations to realise these rights for ‘their’ people, and to seek international assistance if they need it? Or does it mean that states have an obligation to realise these rights for all people, directly for their own inhabitants, and through international assistance for everyone else? If the latter interpretation was the correct one, then on what grounds would governments prioritise their inhabitants? Or shouldn't they; should they support the rights of all people equally? That latter – very egalitarian – interpretation was attractive, but not quite realistic; I could not imagine the people of Belgium – the country I am from – agreeing to share all their tax contributions with the entire world.

I then looked up the most recent ‘concluding observations’ about Belgium. For the readers who are not familiar with the role of the Committee on Economic, Social and Cultural Rights, that committee was created to monitor how states that have ratified the International Covenant are progressing (or not). These states write periodic reports and the Committee makes observations about the reports. The most recent I could find in 2001 were the concluding observations from November 2000, in which the Committee “notes

with concern that, in 1998, Belgium devoted only 0.35 per cent of its gross domestic product (GDP) to international cooperation, while the United Nations recommendation in this regard is 0.7 per cent of GDP for industrialised countries.” (Committee on Economic, Social and Cultural Rights 2000). Obviously, with 0.7 per cent of GDP, Belgium – or even all high-income countries together – could never attain in the rest of the world the same level of realisation of the right to health as at home; thus the Committee did not support the egalitarian interpretation of article 2(1). But if the other interpretation were correct – the one according to which states needing assistance have an obligation to seek assistance, while states that can provide assistance do not really have any obligation to do so – the 0.7 per cent recommendation was based on no substantial legal argument.

The Committee on Economic, Social and Cultural Rights does not only issue ‘concluding observations’ as explained above, but also writes ‘general comments’ on issues arising from the Covenant, which are somewhat authoritative interpretations. One of the first such comments – General Comment 3, issued in 1990 – was about “the nature of States parties’ obligations”. There I found this: “The Committee notes that the phrase “to the maximum of its available resources” was intended by the drafters of the Covenant to refer to both the resources existing within a State and those available from the international community through international cooperation and assistance.” (Committee on Economic, Social and Cultural Rights 1990). But what does “those available from the international community” mean: those that happen to be available because of decisions voluntarily made by some wealthier states, or those that should be available because of legal obligations? This was not particularly helpful.

More helpful, in my opinion, was the comment – still in General Comment 3 of 1990 – about core obligations: “the Committee is of the view that a

minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party". This idea was further developed in subsequent general comments, including in General Comment 14 of 2000 about the right to health (Committee on Economic, Social and Cultural Rights 2000). General Comment 14 affirmed once again the idea I disliked as a student (and still dislike, by the way) – which is that social human rights are 'movable' and depend on the wealth of the state one happens to live in – in paragraph 9: "The notion of "the highest attainable standard of health" ... takes into account both the individual's biological and socio-economic preconditions and a State's available resources." So, bad luck if you live in a poor country! But it also affirmed and described, in paragraphs 43 and 44, core obligations and "obligations of comparable priority".

The idea is that every human right, even though its full realisation depends on circumstances, has a core content that cannot be made dependent on circumstances, otherwise the right to health itself would be meaningless. For example, if in a particular country there are severe tensions between two different ethnic groups, the government could outlaw all public statements accusing groups of having certain characteristics – statements like "all these people are thieves" – and that could be an acceptable limitation of the freedom of speech. Depending on the circumstances, the Convention on the Prevention and Punishment of the Crime of Genocide would even oblige governments to take such measures. But if it were accepted that circumstances can justify criminalising any related critique of the government – statements like "our government is not dealing properly with theft" – then the right itself becomes meaningless.

There must be a core content of every human right: if there is not, then human rights are not really human rights but human privileges for those living under the adequate circumstances.

And if there is a core content of every human right, there are corresponding core obligations. With regard to the right to food, the Committee defined the core content of that right as "availability of food in a quantity and quality sufficient to satisfy the dietary needs of individuals, free from adverse substances, and acceptable within a given culture" (Committee on Economic, Social and Cultural Rights 1999); or in other words: whatever it takes to avoid starvation. If food is a human right, then every human being should at least have access to enough food to avoid starvation. (We know that this is not a reality yet, but there is a big difference between taking notice of a reality and qualifying a reality as justifiable because of circumstances. Even in the face of widespread slavery, one could affirm freedom from slavery as a human right.)

What would the core content of the right to health look like? Analogical to the right to food and avoiding starvation, the right to health could include whatever it takes to avoid... avoidable serious disease or death. That may have been the approach used by the Committee on Economic, Social and Cultural Rights (2000: 13) when it described the core obligations arising from the right to health:

- (a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups;
- (b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
- (c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
- (d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;

(e) To ensure equitable distribution of all health facilities, goods and services;

(f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population;

...

Each of these core obligations would, if unfulfilled, lead to avoidable serious disease or death. Of course, even if or where these obligations are fulfilled, people will still become sick and die, but the core obligations are about addressing the relatively easily avoidable causes of disease or death: providing water, food, sanitation, and primary health care. One could argue that according to these criteria, even the most expensive medicine or medical intervention that is life saving for a very limited number of people only is to be considered as being included in the core content of the right to health. But the reference to “essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs” cleverly avoids the problem, as the World Health Organization (WHO) provides a regularly updated ‘model list’, considering “minimum medicine needs for a basic health_care system, listing the most efficacious, safe and cost_effective medicines for priority conditions” (World Health Organization 2012).

Back in 2001, when the Declaration of Commitment on HIV/AIDS mentioned that “access to medication” is one of the fundamental elements of the right to health, the medication needed to treat AIDS still wasn’t on the WHO Model List of Essential Medicines – it was included in 2002 (World Health Organization 2002), and MSF played an important role in making that happen. So when I received the Declaration of Commitment on HIV/AIDS in October 2001, I already knew that these medicines would be included in the Model List, and that access to these medicines would therefore be part of the core content of the right to health. By then, the cost had drop-

ped to \$ 365 per patient per year – in countries like Mozambique where generic versions were allowed, that was. But that still didn’t fit into the budget of the Ministry of Health, which was about US\$ 10 per inhabitant per year. Not everyone in Mozambique needed AIDS treatment. Given the adult HIV prevalence rate estimated at 15 per cent, we estimated that up to 30 per cent of the population would need AIDS treatment. (When you start providing effective AIDS treatment, HIV prevalence goes up simply because many HIV positive people who would have died no longer do.) Assuming that the cost of basic AIDS treatment would go down to US\$ 100 per patient per year in the long run – which did happen – we still needed a budget of US\$ 30 per inhabitant per year. Human right or not, core obligation or not, the Government of Mozambique could not afford it. But in its General Comment 14 of 2000 about the right to health, the Committee also clarified, in paragraph 45, that “it is particularly incumbent on States parties and other actors in a position to assist, to provide “international assistance and cooperation, especially economic and technical” which enable developing countries to fulfil their core and other obligations.” That made sense: a core content of the right to health, to which all human beings are entitled, and for which all human beings should support each other – through national and international solidarity.

And that meant that international assistance as we know it – essentially charity – is not good enough. We need reliable financial transfers within countries and between countries.

Although I wrote an opinion paper for a Belgian newspaper about the right to health and how it would lead to global social protection in December 2001, it took me until December 2006 before I wrote it as an academic paper, with Katharine Derderian and David Melody (Ooms et al. 2006). This argument became the cornerstone of my doctoral thesis (Ooms 2008), and, with Rachel Hammonds (Ooms &, Hammonds 2010), we

used it in an article taking up a challenge launched by Norman Daniels – who reasoned along the lines of the content of the right to health being limited by the resources available at the national level, but who, at the same time, judged “Strongly Statist Versions of Relational Justice” to be deeply unsatisfactory (Daniels N 2008).

When I finalised my doctoral thesis, the interpretation according to which states have obligations to provide assistance to other states – or to people living in other states – was still quite controversial. But in September 2011, at a gathering convened by Maastricht University and the International Commission of Jurists, a group of experts in international law and human rights adopted the ‘Maastricht Principles on Extraterritorial Obligations of States in the area of Economic, Social and Cultural Rights’. These principles confirm the existence of an obligation to provide international assistance, as part of a wider obligation of international cooperation (Group of experts 2011). As one of the members of that group, I felt as if we had competed a new logic that had started with General Comment 14 about the right to health of 2000, and that had become a reality with the Declaration of Commitment on HIV/AIDS of 2001 – a reality only for HIV/AIDS, however. The Global Fund to fight AIDS, Tuberculosis and Malaria was (and still is), in my opinion, the embryonic version of a global social protection scheme. To implement the Maastricht Principles on Extraterritorial Obligations a much more solid and wider global social protection scheme would be needed – building on the Global Fund, or something else.

Additional half argument: global social protection for health is a matter of global social justice

During my third year as executive director of MSF Belgium, in 2006, I started writing about the humanitarian and human rights arguments that are explained above. Professor Marleen

Temmerman of the University of Ghent – a friend of our family who had helped my wife deliver both of our children – encouraged me to work on a doctoral thesis. I was not exactly bored in my job, but a bit frustrated – it felt as if I was creating an environment for everyone else to be innovative and creative, while not having time left to do any creative thinking myself. So I accepted Marleen’s challenge, and obtained my ‘Doctor of Philosophy’ title in 2008.

One of the chapters that did not make it into my final thesis was about global justice. In 2003, James Orbinski, the former international president of MSF (who accepted the Nobel Peace Prize in 1999), had introduced me to Thomas Pogge – to the philosopher and to his thinking. Pogge’s arguments seemed very close to the ones I was working on, but on a deeper level. When the time came to finalise my thesis, I had still not mastered the philosophical arguments well enough and left that chapter out.

In 2009, Pogge invited me to be the ‘Global Justice Fellow’ at the Whitney and Betty MacMillan Center for International and Area Studies at Yale, for the 2009-2010 year – an opportunity I could not refuse. Pogge’s arguments are influenced by John Rawls’ ‘Theory of Justice’ and Rawls’ ideas about ‘distributive justice’ in particular, but Rawls himself had rejected the application of his theory at the international level suggested by Pogge. That reminded me of the paradoxical attitude (in my opinion) of many people involved in international assistance who seem to feel that solidarity within a country is something good while solidarity across borders is deeply problematic or even wrong. So this was a good opportunity to try and understand Rawls, and indirectly all those people who – with the best of intentions – argue against international solidarity in the long run.

On my arrival at Yale, Pogge asked me why I believed that health is a human right, and what that meant. My answer, as a lawyer, was simple:

health is a human right because there are human rights treaties in which health is mentioned as a human right, and what that means is mentioned – to some extent at least – in the treaties too. “So,” I remember Pogge asking, “before the treaties were signed, health was not a human right?” After a year of chewing on that bone, I came up with two answers. Both of them were inspired by Rawls. Rawls became famous for his thought experiment known as ‘the veil of ignorance’. It was intended to illustrate a way to identify “the principles that free and rational persons concerned to further their own interest would accept in an initial position of equality as defining the fundamental terms of their association” (Rawls 1999: 10.) – if you can find the principles these people would have adopted when designing their ideal society without knowing which positions of this society they would occupy, i.e. from behind ‘a veil of ignorance’, then you have the principles of a just society. In itself, this thought experiment never really convinced me, I must admit. But it is essentially a metaphor that unites several other concepts of justice, of which two are particularly enlightening, in my opinion. The first is about justice as fair and therefore stable cooperation. Simply put: a society should try to be a fair system of cooperation (Rawls 2005: 11); if the terms of cooperation are felt to be unjust by many participants, the cooperation will not work efficiently. So if a society is just it will be an efficient cooperation, and if it is not an efficient cooperation, it probably isn’t just – a bit like the proof of the pudding being in the eating.

The second is about justice as doing no harm to each other – the idea at the core of Pogge’s work, which Rawls may have rejected as too simplistic, but which shines through the cracks of his more sophisticated arguments. For example, when Rawls argues that “background institutions of justice must work to keep property and wealth evenly enough shared over time to preserve the fair value of the political liberties and fair equality of opportunity over generations” (Rawls 2003: 51), he is essentially arguing that

wealth being distributed ‘too unevenly’ is a threat to equality of opportunity. Those who have too much wealth are harming others. Branko Milanovic, calls this ‘bad inequality’ or inequality that “provides the means to preserve acquired positions”, as opposed to ‘good inequality’ or inequality that “is needed to create incentives for people to study, work hard, or start risky entrepreneurial projects” (Milanovic 2005: 12).

My first answer to Pogge was about justice as fair and stable cooperation, and inspired by the science of natural evolution – I prefer not to use the expression evolutionary theory. The science of natural evolution explains why human beings are inclined to observe limitations when they harm each other for their own interests, like fighting for food, and are also inclined to support the other who needs support to remain a valid member of the group. These are inclinations that allow the individual to thrive within a cooperative group. Readers who are familiar with the science of natural evolution may think I succumbed to the theory of ‘group selection’ – according to which certain inclinations or physical qualities spread because they make the group that has them fitter – and abandoned the more orthodox theory of ‘gene selection’ – according to which such inclinations and physical qualities are attached to genes, and genes only spread if they make their individual possessors fitter. But let me reassure them; I am a rather strict adept of gene selection. However, I think that ‘kin selection’ is a form of gene selection: genes spread if they make their possessors fitter, but that also happens if the behaviour of one possessor of a particular gene promotes the chances of survival and procreation of his or her sisters and brothers, who have about 50 per cent chances of possessing the same gene. A cluster of genes imposing inclinations to support each other and to observe limitations when harming each other could have been quite successful within a relatively small tribe of hunters and gatherers of which most members were cousins, if not siblings. A cluster of genes imposing exactly the

same inclinations, but only under a condition of reciprocity, would have been even more successful. And that reciprocity would mean that the occasional intruder not possessing these genes would not be able to exploit the cooperative inclinations of most members of the tribe.

Human rights, then, can be understood as translations of these genetic inclinations: when small nomadic tribes became settlements, settlements became cities, and cities became states, these inclinations needed to be formalised and codified. Instead of prescribing decent cooperative behaviour between individuals, human rights describe minimum standards of behaviour of networks of cooperation – societies – towards individuals. If human rights are still – according to the treaties – predominantly about what your government cannot do to you, or what it must do for you, it is because countries are still perceived as the main networks of cooperation. As long as governments of countries guarantee human rights to all inhabitants, it means that all cooperation happens according to minimum standards. The stronger person cannot enslave the weaker, as the government would interfere. The stronger person cannot use violence against the weaker, as a monopoly of violence has been given to the government, and the government must ensure fair trials before using violence. The stronger person can try to exploit the weaker, but the stronger will have to pay taxes that will provide food, healthcare and education to everyone, and so there are limits to the exploitation that can happen.

But the reality of countries being the main networks of cooperation is changing, rapidly. From the perspective of a small grower of coffee beans in Kenya, the main network of cooperation is not Kenya, not the People of Kenya nor the Government of Kenya, but the global coffee market. The traders, the buyers, and the consumers of coffee are the members of the 'global coffee tribe'. They 'cooperate', but have no institutions to make sure that the conditions of co-

operation live up to minimum standards of decency. Each member of the global coffee tribe negotiates for the highest possible profits or benefits, often without realising that as a result of this uncorrected cooperation, many coffee growers cannot afford to take their children to a health centre when needed.

This kind of uncontrolled cooperation that causes huge profits for some and inhumanly low living conditions for others goes against the natural inclinations and expectations of the people who are losing out. They may accept uneven distribution of the products of cooperation, but not a distribution that is so extremely uneven that they are unable to feed their children. If they 'accept' the present situation, it is because they have no other choice, and that creates a very unstable basis for cooperation in other areas where the winners of global trade may be in a more vulnerable position. That is what I tried to explain in 'Why the West Is Perceived as Being Unworthy of Cooperation' (Ooms 2010). If we want to have smooth cooperation at the global level, we will have to make sure that everyone involved in it will benefit from it, accepting uneven distribution only within limits. As we do not always realise how very innocent choices – like going to one coffee shop because it is a bit cheaper than the next one – encourage the global market dynamics that lead to extremely uneven distribution of the products of cooperation, we need global social protection to correct those dynamics.

My second answer to Pogge was about justice as doing no harm to each other. Reading Rawls about "background institutions of justice" that "must work to keep property and wealth evenly enough shared over time to preserve the fair value of the political liberties and fair equality of opportunity over generations" (Rawls 2003: 51), reminded me about a phenomenon that Gunnar Myrdal had identified a few decades earlier, and called 'cumulative causation'. Centres of economic growth, like families, clans, cities, or even

countries, invest their profits in additional competitive advantages and becoming even stronger, while the periphery of these centres undergoes a ‘backwash effect’ and becomes even weaker (Myrdal 1957: 12). To illustrate that his theory of cumulative causation really is common sense, Myrdal referred to Matthew’s Gospel: “For to the one who has, more will be given, and he will have an abundance, but from the one who has not, even what he has will be taken away” (Matthew 13:12). Later, the phenomenon became known as the ‘Matthew effect’ in economics (Rigney 2010). As mentioned above, Milanovic (2005: 12) calls the problem ‘bad inequality’ or inequality that “provides the means to preserve acquired positions”, as opposed to ‘good inequality’ or inequality that “is needed to create incentives for people to study, work hard, or start risky entrepreneurial projects.”

For the sake of simplicity, allow me to use ‘bad inequality’ as a generic expression that captures Myrdal’s ‘backwash effect’ and the problem that Rawls described when arguing for ‘background institutions for justice’: that if property and wealth are not evenly enough shared over time, the value of the political liberties and fair equality of opportunity are jeopardised. Now, is bad inequality a form of doing harm – i.e. harm done by those who have the means to preserve their privileged positions, who use these means, and who by using these means fix others in their underprivileged positions? One can argue that as long as the people enjoying privileged positions have no intention to keep the others down, they are not causing harm: it is the situation that causes harm. But one can also argue that if people enjoying privileged positions understand ‘bad inequality’ and how it works, they should either change the situation or abandon their privileged positions. An intellectual middle ground could be to consider social protection as a kind of insurance against unintended, unidentifiable and unforeseeable harm-doing. Whenever we participate in cooperation, we do not really know if the uneven distribution of the products of coopera-

tion will be the consequence of uneven effort or the consequence of uneven prior positions. To be sure that we do no harm, we accept that a share of the products of cooperation be redistributed in accordance with needs, and that all people keep certain freedoms, regardless of their poverty or wealth.

If ‘bad inequality’ is a real problem, then we should wonder if it remains confined within the borders of countries. Because of the nature of the problem, we really have no reason to believe it would remain confined within countries’ borders, and therefore we need global social protection, as Hammonds and I argue in a chapter of a still unpublished book (Ooms & Hammonds forthcoming).

All in all, this probably isn’t an additional argument, but it is a foundation for my second argument. Health is a human right, and at least for its core content, the corresponding duties fall on humanity. That is what justice requires, and we need global social protection to implement it.

Third argument: global social protection is a matter of enlightened self-interest, to avoid a ‘tragedy of the commons’

Trying to answer Pogge brought me to read Myrdal’s works again, and it brought me back to Myrdal’s prediction that global economic integration would be bad for poorer countries: “On the international as on the national level trade does not by itself necessarily work for equality. It may, on the contrary, have strong backwash effects on the underdeveloped countries” (Myrdal 1957: 51-52). But Myrdal’s predication was not entirely right. Until the end of the 20th century, global inequality evolved as Myrdal had predicted; rich countries became richer, and poor countries became poorer. Inequality between countries – measured by comparing the average income of each country (and ignoring the differences in income between people living in the same coun-

try) – rose. By the end of the 20th century, however, this trend reversed; inequality between countries has been falling ever since. According to Glenn Firebaugh (2003: xi) “income inequality across nations peaked in the last third of the twentieth century and is now declining”, however, “[a]t the same time, inequality within nations – which had been declining over the first half of the twentieth century – has begun to rise”.

What is going on here? In 1997, Dani Rodrik (1997: 69) warned against “social disintegration as the price of economic integration”. In a later book he argued: “Governments today actively compete with each other by pursuing policies they believe will earn them market confidence and attract trade and capital inflows...” (Rodrik 2007: 201). Vic George and Paul Wilding argue along the same lines: “Concern about competitiveness has obviously put social security schemes under pressure given the way in which the debate about competitiveness has focused primarily on employment costs and levels of social benefits and taxation and the supposed damage they can do to competitiveness” (George & Wilding 2002: 70).

Most research about the consequences of the quest for competitiveness on social policy has focused on wealthier countries – countries with rather generous social protection mechanisms that are now under pressure. There is evidence, however, that poorer countries, while trying to establish their social protection, are hampered by the very same quest for competitiveness (Avi-Yonah 2001). The same author concludes: “it can be argued that given the need for tax revenues, developing countries would in general prefer to refrain from granting tax incentives, if only they could be assured that no other developing country would be able to grant such incentives” (ibid.).

If correct, then social protection has many features of a common-pool resource, and it may be argued that it is becoming the victim of a parti-

cular kind of ‘tragedy of the commons’: not over-exploitation but under-exploitation is the problem. By under-exploiting the potential for taxation and social protection, countries try to attract economic activity from other countries, which decreases these other countries’ ability to raise taxes. The solution to a tragedy of the commons is regulation or self-regulation, and that is precisely what Pierre Pestieau (2005: 10) proposes: “[t]he only way to reverse such an expected outcome is to rely on cooperation between national governments”.

What should this cooperation include? Somehow, it should oblige all countries to adopt certain minimum levels of social protection – and therefore minimum levels of taxation. When wealthier countries’ governments will try to propose that, it seems inevitable that poorer countries’ governments will argue that this is merely an attempt to end a recent trend – a trend of poorer countries capturing a bigger share of the global economy. Richer countries’ governments could reply that minimum levels of social protection are required because of human rights, while poorer countries’ governments could reply that, in this case, international assistance is required because of human rights, too.

This would lead to a global social protection regime, including a global social protection floor – minimum levels of social protection to be observed by all countries – and a global social protection fund, to channel transfers from richer to poorer countries. A global social protection regime would serve the interests of the common people of all countries. The common people of poorer countries would benefit from more reliable international assistance, and from the dampening of tax competition. The common people of wealthier countries would benefit from the dampening of tax competition. These arguments are being elaborated in a paper written with many others, to be published in 2013 (Ooms et al. forthcoming).

Conclusion

The more I think and write about it, the more it seems obvious: global social protection is the inevitable next step in a natural evolution that started when individual members of tribes of hunting and gathering humans understood they had to respect and support each other. The 20th-century translation of that understanding is the Universal Declaration of Human Rights and its two International Covenants, both focusing on duties of national governments towards the people under their jurisdiction. The 21st-century translation of that understanding will be a clarification of the Universal Declaration of Human Rights and its two International Covenants with regards to 'extraterritorial obligations' or, in other words, a clarification of the duties of humanity towards humanity. This is already taking shape in the 'Maastricht Principles on Extraterritorial Obligations of States in the area of Economic, Social and Cultural Rights' (Group of Experts 2011), and, in the area of civil and political human rights, in the concept of the 'Responsibility to Protect' (International Commission on Intervention and State Sovereignty 2001).

All in all, my three and a half arguments are, essentially, a single argument. The idea of autonomous, self-containing and sovereign states has become an anachronism. The reality of the 21st century is that people are members of a global society. And therefore, they have humanitarian duties towards each other (across borders); they have duties of justice to support the realisation of each other's human rights (across borders); and they serve their own interests by supporting the realisation of each other's human rights (across borders).

In hindsight, the step from supporting Doctors Without Borders to supporting Social Protection Across Borders is only an incremental one. Let's take it. ■

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