Oxford Handbooks Online

The Human Right to Health and Global Health Politics

Gorik Ooms and Rachel Hammonds

The Oxford Handbook of Global Health Politics
Edited by Colin McInnes, Kelley Lee, and Jeremy Youde

Subject: Political Science, Public Policy Online Publication Date: Feb 2018
DOI: 10.1093/oxfordhb/9780190456818.013.30

Abstract and Keywords

This chapter discusses how the human right to health could be and has been used to influence global health politics to place greater emphasis on the interests of all people. It explores whether this right is a norm to which states adhere, or could adhere, because they identify with its underlying values. Three important obstacles are addressed. Global HIV/AIDS activism used the right to health to pressure influential states into compliance on concrete measures and therefore defined an important element of the human right to health. Earlier attempts to use this right to influence global health politics failed to advance similarly concrete measures. Those who want to use the right to health in support of universal health coverage should understand the strengths and weaknesses of this tool and advocate for concrete measures rather than broad principles.

Keywords: human rights, global health politics, right to health, HIV/AIDS, universal health coverage

---

Until the 1990s much of the scholarly debate in international relations was defined by ‘realism’, which assumes that states are self-interested and therefore most often behave in ways that predominantly preserve or promote their own interests. The ‘intellectual hegemony’ of realism ‘was the perspective against which new ideas had to be tested’ (Katzenstein, Keohane, and Krasner 1999, 18). It not only dominated research on security and trade, but also influenced research on international cooperation: ‘[t]heories of international cooperation … made a big leap forward by accepting the assumption that states are self-interested and have conflicts of interest with one another’ (Martin 1999, 52).

Since the 1990s ‘constructivism’ has challenged realism’s dominance, as both a critique and a complementary school of thought. In defining constructivism as complementary to realism, constructivists consider norms, values, ideas, and other ‘social constructs’ to be interests of a different kind. As Wendt (1999, 242) notes, ‘[t]he vast majority of states today see themselves as part of a “society of states” whose norms they adhere to not because of on-going self-interested calculations that it is good for them as individual states, but because they have internalised and identify with them’. Thus for constructivists, states comply with international norms because these norms represent a kind of interest, even if compliance may require that they sacrifice some of their other interests.

Realism does not rule out cooperation between states intended to address transborder issues, like health problems. On the contrary, the simple fact that viruses do not respect state borders creates a solid ground for 'international cooperation in the national interest' (International Task Force on Global Public Goods 2006). Global health politics, from a realist perspective, is likely to be informed by the interests of states with the power and money to influence global health politics and therefore is likely to focus on cross-border issues that affect these states, such as the spread of infectious diseases.

A constructivist perspective allows one to understand why global health politics may go beyond 'international cooperation in the national interest' and addresses global health inequalities unrelated to infectious disease. From a constructivist perspective, the most likely candidate for a norm that states may want to comply with, because they value the norm itself, is the human right to health, as enshrined in the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Rights of the Child, and other international human rights law treaties. Other norms, like the Millennium Development Goals (MDGs) and their successors, the sustainable development goals (SDGs), may play a similar role. From an international law perspective, they do not have the same authoritative value as a legally binding treaty, but they may have more political value and therefore more influence on global health politics.

The influence of the human right to health on global health politics can be explored from numerous angles. We focus in this chapter on two distinct approaches, the normative and the descriptive, each of which answers different types of questions. The normative approach employs right to health norms to depict what governments (and other actors) ought to do so as to describe how global health politics would look if the right to health drove politics. The descriptive approach examines the reality of global health politics to understand why global health's 'politicians' do what they do, to determine the extent to which global health politics is influenced by the right to health. Combining both approaches is more illuminating. A strictly normative approach would lead to a description of an ideal type of global health politics that bears little resemblance to the present reality. Furthermore, it would contain many lacunae, as the human right to health is essentially a principle that requires further crystallization through application in real life, as explained below. A strictly descriptive approach would be difficult; if we do not know what right to health compliant global health politics should look like, we cannot judge whether the world is moving towards it (or not).

Combining both approaches requires a note of caution. While both the normative and descriptive approaches can illuminate the same topic, they belong to different epistemological dimensions. They look for, or claim, distinct kinds of truths. These statements—(a) because of the law, cars on this highway should not drive faster than 120 kilometres per hour (kmh) and (b) cars on this highway are not driving faster than 120 kmh because of the law—may look very similar but are quite different. Statement (a) can be true, even if all cars are driving much faster than 120 kmh. This is because it is a normative statement, which can be true even if the empirical reality seems to tell a different story. Furthermore, even if all cars drive at 120 kmh or slower, statement (b) could still be untrue. For example, drivers may not care about the law, but respect the speed limit out of fear that faster driving could damage their cars. Thus, even when we observe global health politics that is in line with the right to health, it does not necessarily mean that it is in line with the right to health *because of* the right to health.

We therefore divide this chapter into two sections. The normative section briefly explores what global health politics should do to be compliant with the right to health, then discusses three main obstacles to greater compliance. First, we examine the post–World War II evolution of human rights, from citizens' rights to human rights. Second, we explore the legacy of the historical cleavage of human rights into two international treaties, the ICESCR, often characterized as costly entitlements, and the International Covenant on Civil and Political Rights

(ICCPR), often erroneously classified as cost-free freedoms. Third, we introduce the idea of human rights as a lever, not a force. The lack of 'systematic evidence to suggest that ratification of human rights treaties in the UN system itself improves human rights practices', in combination with the finding that 'the growing legitimacy of human rights ideas in international society … provides much leverage for nongovernmental actors to pressure rights-violating governments to change their behaviour' (Hafner-Burton and Tsutsui 2005, 1401), indicates that compliance by states should only be expected if civil society holds states accountable.

The descriptive section explores how the human right to health has informed, and is informing, global health politics. The most often cited example of the right to health's influence on global health politics is the AIDS response (McInnes and Lee 2012). We use this case to explore, and tentatively confirm, the idea of human rights as a lever, then explain how civil society uses the right to health to formulate specific claims and to press the international community into honouring these claims. We then revisit recent history to explore why the World Health Organization's (WHO's) Health for All by the Year 2000 strategy (WHO 1981), which was also explicitly grounded in the human right to health, did not influence global health politics in the way it should have (for the strategy to succeed). Finally, we turn to the new WHO strategy of universal health coverage (UHC), again—but less explicitly—grounded in the human right to health, and explore what it would take to influence global health politics in a right to health compliant manner.

The Normative Approach to Health as a Human Right

From Citizens' Rights to Human Rights

While it is now taken for granted that '[h]uman rights are rights held by individuals simply because they are part of the human species' (Ishay 2008, 3), this was not self-evident when the expression 'human rights' gained currency. The French Declaration of the Rights of Man and of the Citizen of 1789 was, as the title suggests, a declaration about the rights of (some) French citizens. It was a product of the French Revolution of 1789, and 'in 1791, the French revolutionary government granted equal rights to Jews; in 1792, even men without property were enfranchised; and in 1794, the French government officially abolished slavery' (Hunt 2007, 28). Women were not enfranchised because they were not considered full-fledged citizens. The French National Assembly also made a distinction between 'active' and 'passive' citizens. Women, servants, and foreigners were passive citizens; they did not have the same rights as 'active' citizens. Furthermore, the French did not take it upon themselves to spread human rights to the inhabitants of other countries. The 1776 US Declaration of Independence may well have mentioned that 'all Men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty, and the pursuit of Happiness', but many of the signatories saw no contradiction in being slaveholders. Both documents were declarations of the rights of citizens of given countries, and the corresponding duties rested upon the governments of these countries. These were not human rights declarations.

The world wars during the twentieth century, and World War II in particular, forced a revision of the concept. If human rights were only citizens' rights, then the rights of German citizens under Nazi rule may have been only those rights recognized by Hitler's government. This was untenable. The 1948 Universal Declaration of Human Rights (UDHR) refers to the atrocities of World War II and proclaims the human rights of 'all human beings' (article 1), 'everyone' (articles 2, 3, 6, etc.), and 'all' (article 7). Thus, the UDHR seems to leave little ambiguity about the nature of the rights it proclaims: that is, human rights, not citizens' right. However, some ambiguity remains because of the way the corresponding duties are allocated in the UDHR. On duties, the UDHR remains

ambiguous. On the one hand, it seems to place the corresponding duties upon humanity: ‘Member States have pledged themselves to achieve, in co-operation with the United Nations, the promotion of universal respect for and observance of human rights and fundamental freedoms’. On the other hand, the UDHR calls itself ‘a common standard of achievement for all peoples and all nations’. Thus, the duties seem to remain with states, or more precisely, ‘all peoples and all nations’.

Does the ambiguity about corresponding duties affect the nature of the rights of humans or citizens? Much has been written about the relationship between rights and duties. To briefly summarize, some scholars argue that a human right only qualifies as such if it is enforceable; it is ‘essential to the existence of a set of “rights” that there be some specifiable, and more or less effective, mechanism for enforcing them’ (Geuss 2001, 143). If this is so, then being held as a slave was not a human rights violation as long as some states tolerated or promoted slavery (and other states did not intervene); the essence of the right to freedom sprang into existence when all states agreed to abolish slavery. Other scholars argue that human rights only qualify as such when they are at least claimable, when the duty bearers and the content of the duty can be identified (O’Neill 1996). Whether the duty bearers *do* live up to their duties is a different matter; what matters is that they *should*: that is enough for rights owners to have a legitimate claim. Some scholars agree with this ‘claimability’ condition but defend a softer version of it: it is not essential that the duty bearers can be clearly identified or that the extent of their duties is clearly defined; what matters is that duty bearers are identifiable in theory, if not in practice (Griffin 2008). If the links between duty bearers and duties are not clear, it only means that more work needs to be done to clarify them. However, it is essential that some people or institutions, somewhere on the earth, are able to fulfil the corresponding duties.

We side with the soft version of the claimability condition: a human right can only be a human right if it is possible, at least in principle, to identify people and institutions who can, together, ensure that right to all human beings. If no institution or collective of institutions is able to ensure a given right to all humans, the claim is void. If it is possible to imagine how institutions could ensure a given right to all humans, the claim has substance. Of course it is a problem if the corresponding duty bearers have not been identified (yet), but the claim makes sense and requires identifying duty bearers. We argue that it would be more problematic if the duty bearers were being identified in such a way that the best imaginable version of the enjoyment of the human right is either meaningless or very different for different human beings.

Unfortunately that is exactly what happened when the UDHR was translated into legally binding treaties. The UDHR is a declaration, not a treaty; it had to be ‘translated’, and further elaborated, into a treaty. Furthermore, the UDHR contains two different kinds of rights: ‘freedoms’ and ‘entitlements’. Freedoms are claims to non-interference in some important aspects of a person’s private life: going where one wants to go, thinking what one wants to think, and believing what one wants to believe. Entitlements are claims to active support, when needed, for a person to subsist in dignity: the provision of water, food, housing, education, healthcare, and so forth. Political and ideological disagreement over the role of the state in providing for human rights leads to a division in the international community. Two international covenants (treaties) were elaborated, one on civil and political rights (freedoms), the other on economic, social, and cultural rights (entitlements). This division became one of the ideological battlegrounds of the Cold War: the ICCPR became ‘the human rights treaty of the West’, while the ICESCR became ‘the human rights treaty of the Eastern Bloc’. Even if most Western states ratified both the ICCPR and the ICESCR, they only took the freedoms seriously (as human rights): freedom of political opinion, freedom of press, freedom of religion, and freedom from arbitrary arrest. The most famous non-governmental organizations (NGOs) in human rights were (and to a large extent still are) focused on freedoms.

Both the ICCPR and the ICESCR identify duty bearers more clearly than the UDHR does. One may argue that they are treaties more about duties than rights, with both the ICCPR and the ICESCR identifying states as primary duty bearers. Article 2(1) of the ICCPR proclaims: 'Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant'. Therefore, the content of the human rights freedoms of a given person is limited by the ability of her or his state. In theory, this does not affect the substance of the human rights mentioned in the ICCPR; as freedoms, they are supposed to be cost free, requiring non-interference by the state. Even the poorest state can allow its citizens and residents to freely express their opinion. In reality, the capacity of states does make a difference; a fair and effective police force and judicial system require significant resources.

Furthermore, realizing human rights depends not only on capacity but also on the willingness of duty bearers. Considering how World War II inspired the UDHR, it does not seem plausible that Hitler's government organized the Holocaust because of the lack of ability to respect human rights (or because there was no UDHR or other legal text clarifying the content of human rights). The Holocaust was the result of an unwillingness to ensure human rights, an intentional exclusion of specific groups of people from citizenry. As explained previously, the weak version of the claimability condition holds that a human right does not have to be enforceable to be a human right; a legitimate claim is sufficient, as long as it is possible, at least in principle, to identify people and institutions that can ensure that right to all human beings. One may thus argue that as long as a state can be identified as a dutybearer—one that is able, even if unwilling—the human right has substance. Considering history, however, we argue that the claimability condition also requires that solutions be available to address the consequences of manifestly unwilling states, simply because manifestly unwilling states are a reality. The ICCPR does not address the problem of unable or unwilling states. Thus, while the list of human rights mentioned in the ICCPR may be the same for all human beings, the substance of these rights differs depending on the country one lives in. We argue that the rights proclaimed in the ICCPR are somewhere between citizens' rights and human rights: they are rights one has, partly by virtue of being a citizen of a given state, partly by virtue of being a human being.

Article 2(1) of the ICESCR proclaims: '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.' Like Article 2(1) of the ICCPR, article 2(1) of the ICESCR also locates the corresponding duties with states, but it contains two qualifiers. First, the corresponding duty is to take steps, to the maximum of a state's available resources, which means explicitly that the substance of the human rights proclaimed under the ICESCR differs between humans, depending on the state they live in. (For example, if you have cancer and you happen to live in a country that is wealthy enough to provide cancer treatment to all citizens who need it, your right to health includes cancer treatment. But if you happen to live in a country that is too poor to provide cancer treatment, your right to health does not include a legitimate claim to cancer treatment.) Thus the ICESCR is quite explicitly a treaty about citizens' rights. However, the second qualifier mitigates that and turns the ICESCR into a treaty about rights that are somewhere in between citizens' and human rights: states must take steps, individually and through international assistance. (If you have cancer and live in a country that is unable to provide cancer treatment to everyone who needs it, you may be tempted to use the ICESCR as the basis of a claim upon the international community.)

Thus the ICESCR seems to confirm and codify duties across state borders. However, the precise nature and scope of these duties remains undefined, and the international obligation to provide assistance became one of the most controversial issues in human rights scholarship. Rather than embarking on an overview of all the opinions and

positions, it is more instructive to cite concluding remarks formulated by Tobin (2012, 368), who explored the issue in relation to the right to health:

> The meaning of the international obligation to co-operate for the purpose of realizing the right to health is far from settled. But its ambiguity and contested nature, especially in the context of international assistance, are not sufficient grounds to relegate this obligation to the periphery in any discussions concerning the right to health. On the contrary it must occupy a more central place given that co-operation between states is critical to ensuring the effective enjoyment of the right to health. The challenge, however, is to provide a persuasive interpretation that can outline the 'concrete measures' required for its effective implementation.

In conclusion, while the UDHR advanced towards human rights (and away from citizens' rights), the ICCPR was a step towards citizens' rights, and the ICESCR did not represent a step towards or away from human rights. In practice, the benefits of human rights remain a kind of 'passport lottery'; not only the enjoyment of human rights, but even the substance of the claims, remains to a large extent defined by the willingness and the ability of states to provide for them. The advent of the ICCPR and ICESCR has coincided with human rights playing an increasingly important role in international relations and diplomacy. Given the preference of wealthier Western countries (and the United States in particular) for ICCPR rights, the role of human rights in international politics has mainly been limited to freedoms. For example, Forsythe's (2006) descriptive book *Human Rights in International Relations* is almost exclusively focused on human rights freedoms. Other scholars have written about the role of 'subsistence rights' in international relations—that is, human rights entitlements, reduced to their minimum essence—but these books are normative, describing the role human rights (entitlements) should have in global politics, not the role they actually played (Shue 1996; Vincent 1986). Even if focused on freedoms, the attention given to human rights in international politics remained limited. The wealthier and most powerful states showed little hesitation in dealing and trading with states (and heads of states) that were notorious human rights (freedoms) violators; such were 'the politics of liberalism in a realist world' (Forsythe 2006, 251).

In the 1990s, however, the genocides in Rwanda and then in the former Yugoslavia shook the international human rights regime as the Holocaust had previously done. Although the Convention on the Prevention and Punishment of the Crime of Genocide, which has clearer international duties, could have applied to these extreme cases of state unwillingness to respect human rights, they highlighted the shortcomings of the existing state-centred human rights regime. When there were doubts about whether a situation qualified as genocide, international human rights law provided little guidance on how the international community should act. These events, together with others, led to the birth of the 'Responsibility to Protect' doctrine, which addresses the boundaries of states' collective responsibility to prevent extreme human rights violations. Whether the Responsibility to Protect will gain the status of a new international legal norm or remain political rhetoric is yet to be determined. As Stahn (2007, 120) concludes, '[r]esponsibility to protect is thus in many ways still a political catchword rather than a legal norm. Further fine-tuning and commitment by states will be required for it to develop into an organizing principle for international society.' Moreover, it does not encompass all human rights, only a limited number of extreme human rights violations, including genocide, war crimes, ethnic cleansing, and crimes against humanity. But it has the merit of highlighting the shortcomings of the state-centredness of the present human rights regime.

With regard to health, it is important to note that at the beginning of the twenty-first century the international community implicitly (not explicitly) accepted collective responsibility for the provision of antiretroviral (ARV) medicines for people living with AIDS in low- and middle-income countries. If wealthier states did not explicitly

acknowledge their status as duty bearers across state borders, they certainly behaved as such. We explore this further below.

The main point is that if one takes the approach of a constructivist and looks at the right to health as a norm that may have guided global health politics so far, or that may provide guidance for global health politics in the future, looking beyond the 'face value' of the human right to health may be somewhat disappointing. This is because international human rights law addresses mainly how states ought to behave at the domestic level. However, by taking a historical perspective, ranging from the eighteenth-century American and French declarations to the 1948 UDHR, 1966 ICCPR, and ICESCR and continuing to present-day state behaviour in response to domestic human rights issues, there is some evidence of a gradual shift from an idea of rights that people have by virtue of being citizens to an idea of rights that people have by virtue of belonging to the human species. This is not much, but it is something to build on.

Freedoms versus Entitlements: Implications for Global Health Politics

For many global health scholars, stating that health is a human right makes little sense. It sounds as though all humans have an entitlement to be healthy, and that is like saying that all human beings have an entitlement to be happy. However, like other human rights, the right to health is a kind of shorthand. It is not a right to be healthy but a legitimate claim to a basket of freedoms and entitlements that can have a positive impact on one's health. For example: both the entitlement to healthcare and the freedom to criticize the government for not providing adequate healthcare can have a positive impact on one's health.

We explained previously that the difference between human rights freedoms and entitlements was a key reason for the elaboration of two different covenants: the ICCPR and the ICESCR. This division has been criticized by many human rights scholars as artificial and misleading. However, while we prefer more sophisticated typologies that reveal the intellectual kinship of all human rights—such as those suggested by Shue (1996) and Eide (2001)—not only has the division resulted in different treaties, entailing different legal obligations, it is also rooted in reality. If all human rights are legitimate claims to mixed baskets of entitlements and freedoms, and no human rights consist of only claims to freedoms or only claims to entitlements, it is clear that in some human rights baskets one will find more freedoms than entitlements, and vice versa. Freedom of speech, for example, does require an entitlement to protection against retaliation by those who do not want certain opinions to be voiced—a journalist who wants to write about crime syndicates needs active protection from the state to have real freedom of expression—but it mostly requires freedoms: non-interference whenever one wants to express an opinion. The right to health, for example, does require the freedom to criticize a health authority not doing what it should do, but it mostly requires entitlements to positive efforts. And this difference—somewhat artificial and somewhat real—has consequences when it comes to exploring international duties.

According to Shue (1996, 19), human rights 'are everyone's minimum reasonable demand upon the rest of humanity'. Even so, we cannot ignore the existence of a world order based on states, and neither did Shue; in his view, states continue to bear the primary duty to ensure the enjoyment of human rights for their citizens, and only if a state fails to do so must 'some other agent at least sometimes … step in'. When it comes to violations of human rights freedoms—presumed to require only non-interference—the concerned state is probably unwilling to do what it should do, because doing what it should do would cost nothing. It is then relatively easy for other states to point a finger at the concerned state and thus to deny their responsibility. When it comes to violations of human rights entitlements, such as not providing appropriate healthcare, the concerned state will often be unable to do what it ought to do, which makes it a much more difficult for other states to reject their secondary duty. We now know the

financial costs of considering access to ARV treatment a universal entitlement—financed with domestic resources where possible, by the international community in countries that cannot afford it—and that gives us an idea of the potential claims if other health issues were to be treated similarly. Therefore, wealthier states are understandably reluctant to accept the principle that human rights 'are everyone's minimum reasonable demand upon the rest of humanity' (Shue 1996, 19), as it would open a seemingly bottomless pit.

The Human Right to Health as a Lever, Not a Force

The third important obstacle to using the human right to health as guidance for global health politics is the finding that ratification of human rights treaties does not in itself improve human rights practices, in combination with the finding that human rights 'provide leverage for nongovernmental actors to pressure rights-violating governments to change their behaviour' (Hafner-Burton and Tsutsui 2005, 1401). In this case, the 'non-compliant governments' would be the ones that have most influence on global health politics. Canada, France, Germany, Japan, Norway, the United Kingdom, and the United States make the biggest financial contributions to global health (Institute for Health Metrics and Evaluation 2017), and we assume here that they are thus the most influential in global health politics. At the domestic level, these states have a generally positive human rights record, which may make us believe that they are, a priori, proponents of all human rights, including the right to health. Decades of social struggle in the nineteenth and twentieth centuries (continuing into the twenty-first century in the United States) expanded access to social rights at the domestic level.

However, when it comes to compliance at the global level, we cannot take for granted the commitment to human rights of these states. First, while Canada, France, Germany, Japan, Norway, and the United Kingdom have ratified the ICESCR, the United States has not. Second, as discussed previously, the shift from citizens' rights to human rights has only recently begun and is far from complete. As Tobin (2012, 340) notes, several states have argued that 'although the need for international co-operation and assistance reflected an "important moral obligation", it was "not a legal entitlement".' Third, all these states have interests that may be at odds with global health politics aligned with the right to health: to avoid being obliged to pay for healthcare for other states' citizens, but also, for example, to continue recruiting health workers from countries where they are needed more, without being labelled a human rights violator. Therefore, we should not expect these states to live up to their international duties unless non-governmental actors pressure them into it.

If the substance of the human right to health remains somewhat vague; if, a fortiori, the substance of the international duties for the realization of the right to health remain vague; and if on top of that, we can only expect states to act upon their international duties if NGOs use the right to health as a lever for their claims, then the role of NGOs in advancing the right to health is more than a strategic one. It becomes a defining one. The successful right to health claims advanced by NGOs upon the global health politics of influential states are not only contributing to the realization of the human right to health, they are also defining the substance of the right to health. For example, before HIV/AIDS activism claimed that access to ARVs is an essential element of the right to health, before UNAIDS and the Office of the High Commissioner on Human Rights (OHCHR) confirmed this claim in 2002 (UNAIDS and OHCHR 2006), before ARVs were added to WHO's essential medicines list (also in 2002, and under HIV/AIDS activist pressure) (Laing et al. 2003), and before the creation of a mechanism that allowed the practical international cooperation required (again in 2002, i.e., the Global Fund), few lawyers would have unequivocally confirmed that access to ARVs is an essential and universal element of the right to health. Since then access to ARV therapy has been cited as a textbook example of the right to health (Wolff 2012; Tobin 2012; Griffin 2008; Chapman 2016).

We therefore agree with Tobin (2012, 368) when he argues that '[t]he meaning of the international obligation to co-operate for the purpose of realising the right to health is far from settled', and that the challenge remains 'to provide a persuasive interpretation that can outline the "concrete measures" required for its effective implementation'. This is a challenge not only for legal scholars but also for global health scholars and NGOs. While we would have liked to end this normative section with a clear and detailed overview of what states ought to do in global health politics to support the human right to health, that is not possible. The 2000 General Comment (United Nations International Committee on Economic, Social and Cultural Rights 2000) contributed greatly to clarifying the contours of the right to health; however, it leaves many important issues unsettled (Forman et al. 2013). As Chapman (2016) argues, the human right to health is an emergent human right; it has not fully crystallized yet, and that is particularly true for its international dimension.

The Descriptive Approach to Health as a Human Right

HIV/AIDS, the Right to Health, and Global Health Politics

When global health and human rights are mentioned together in a single sentence, one can usually expect HIV/AIDS to be mentioned in the next. Indeed, the global HIV/AIDS response has been the 'poster child' of health and human rights advocates and is often mentioned as the example that other health issues (and their advocates) should follow (Forman et al. 2012).

The relationship between HIV/AIDS and human rights was forged at a time when very little was known about HIV/AIDS prevalence outside of the United States, when most of the affected people faced stigmatization and discrimination because of their sexual orientation or profession, and when there was no treatment, all of which contributed to healthcare professionals' reluctance to treat them with dignity. Human rights were invoked, first to shield people living with HIV/AIDS from discrimination and later as an essential element of prevention strategies (Mann 1999). Within less than a decade HIV/AIDS activism evolved into a global struggle, with the human right to health at its centre. The first cases of what later became known as acquired immunodeficiency syndrome (AIDS) were described in a paper in June 1981, the patients being five white homosexual men (Piot 2015). Three years later, Piot et al. published their paper on AIDS among heterosexual men and women in Zaire (now Democratic Republic of Congo) in the *Lancet* (Piot et al. 1984). Five years after that, ACT-UP New York and AIDS Action Now issued the 'Montreal Manifesto' at the Fifth International AIDS conference in June 1989, which demanded an international code of rights for people with HIV, an international development fund to help poor countries to meet their health responsibilities, and 'the conversion of military spending worldwide to medical health and basic social services' (Brier 2009, 156). The Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) was created twelve years later.

The discovery of ARV medicines may have led to a temporary decline in HIV/AIDS activism in the United States, but not for long. Although several chapters of ACT-UP closed, ACT-UP Philadelphia reached out to HIV/AIDS activists in sub-Saharan Africa: 'The emerging new core of ACT UP Philadelphia found members of the city's large black community to be particularly receptive to their message about fighting AIDS in Africa, both because of feelings of ethnic solidarity as well as bonds of personal experience' (Smith and Siplon 2006, 61).

One of the first issues on the agenda of the emerging global HIV/AIDS activism network was the World Trade Organization's (WTO) Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement. TRIPS was an

annex to the Final Act of the Uruguay Round of Multilateral Trade Negotiations, which also included the 1994 Agreement Establishing the World Trade Organization (Gervais 2012). Thus, TRIPS was part of a package deal, a part strongly promoted by many industrialized countries and reluctantly accepted by most low-income countries, as a price to be paid for WTO membership (Correa 2000). The agreement obliged WTO members to adopt minimum standards for intellectual property protection. This in turn had a direct effect on the cost of ARV medicines. In the words of Stiglitz (2008, 181), 'when the trade ministers signed the trade agreement in Marrakech in April 1994, they were in effect signing the death warrants for thousands of people in Africa and other developing countries'.

The TRIPS agreement included some flexibilities, including the possibility for governments to issue 'compulsory licenses' and thus to allow manufacturers of medicines to produce generic (and much cheaper) copies of patent-protected medicines, without the patent owner's permission. Brazil used this flexibility as part of its strategy to provide free ARV treatment (Galvão 2005). South Africa adopted the South African Medicines and Medical Regulatory Devices Act in 1998, which allowed a systematic use of TRIPS flexibilities. A coalition of pharmaceutical companies sued the government of South Africa. Activists from all over the world mobilized against the pharmaceutical companies. In April 2001 the coalition of pharmaceutical companies withdrew its lawsuit (Brier 2009).

According to Barnard (2002, 167), the framing of the lawsuit's withdrawal as a victory of 'the requirements of justice and respect for human rights' was 'seriously misleading', because most countries in Africa were too poor to provide ARV treatment even at reduced costs. But global HIV/AIDS activism did not stop with the end of the lawsuit. In the same month Harvard University faculty members issued the 'Consensus Statement on Antiretroviral Treatment for AIDS in Poor Countries'. 'As individuals committed to equitable access to health care for all peoples and to human rights', the statement acknowledged that 'AIDS treatment will always be more expensive than poor countries can afford, meaning that international aid is key to financing the effort' (Individual Members of the Faculty of Harvard University 2001). It called for a global fund to help developing countries finance AIDS treatment. Echoing the 1989 Montreal Manifesto, this became the next target of global HIV/AIDS activism. When the Global Fund was finally up and running in 2002, allowing the rollout of a global AIDS treatment effort, helped by the President's Emergency Plan for AIDS Relief (PEPFAR), HIV/AIDS activism successfully challenged the practice of making patients pay 'user fees' (Souteyrand et al. 2008) and the imposition of expenditure ceilings by the World Bank and the International Monetary Fund (Rowden 2013; Baker 2010).

Did AIDS activism 'create' a new and universal right to health entitlement? That would be at odds with the concept of human rights: 'rights held by individuals simply because they are part of the human species' (Ishay 2008) and therefore not dependent on the willingness (or not) of states to ensure their enjoyment. In our opinion, AIDS activism 'clarified' one element of the right to health, helping one element of the right to health to 'emerge' from the ambiguities and weaknesses of the international treaties' texts. Other elements are waiting to be ushered in.

Health for All, the Right to Health, and Global Health Politics

A few years before the first cases of HIV/AIDS were described in the medical literature, the International Conference on Primary Health Care took place in September 1978. The Declaration of Alma Ata (International Conference on Primary Health Care 1978), which informed the WHO Health for All by the Year 2000 strategy (WHO 1981), starts with an explicit reference to the human right to health: 'The Conference strongly reaffirms that health … is a fundamental human right'. Yet most global health scholars would probably agree more with the statement that global health politics derailed the health for all strategy (Solar and Irwin 2006) than with the

statement that the health for all strategy had a deep impact on global health politics. How did the former occur, and what should global health politics have done to enable the strategy?

If, in line with the human rights as a lever idea, we look for the claims made by NGOs in Canada, France, Germany, Japan, Norway, the United Kingdom, and the United States in the name of right to health, for their governments to enable the health for all strategy, the first challenge is to identify these NGOs. While there are many references to the Alma Ata 'movement' (Packard 2016; Birn, Pillay, and Holt 2017), the movement was composed predominantly of civil servants, academics, and WHO and UNICEF staff. The Alma Ata equivalents of ACT-UP and Health GAP did not exist. The People's Health Movement (PHM) was born in 2000, twenty-two years after the declaration.

When we scan the Declaration of Alma Ata itself for what the governments of Canada, France, Germany, Japan, Norway, the United Kingdom, and the United States should have done, we can find many vague references to international cooperation, such as 'urgent action by all governments, all health and development workers, and the world community'; 'a most important world-wide social goal'; and 'social target of governments, international organizations and the whole world community in the coming decades' (International Conference on Primary Health Care 1978). The comment that a 'genuine policy of independence, peace, détente and disarmament could and should release additional resources' comes close to 'the conversion of military spending worldwide to medical health and basic social services', demanded in the Montreal Manifesto (Brier 2009). Yet it was somewhat contradicted by the statement that primary healthcare (PHC) should be provided 'at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination' (International Conference on Primary Health Care 1978). A global fund, as demanded in the Montreal Manifesto, would have undermined that spirit of self-reliance. Those who wrote the Declaration of Alma Ata were aware that PHC would cost more than many countries could afford. The proposed solution was not a global fund for PHC, but a call for '[e]conomic and social development, based on a New International Economic Order [NIEO]', as being 'of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries' (International Conference on Primary Health Care 1978). The NIEO was a 'two-pronged program—aimed at securing an equitable distribution of the world's resources and meeting the minimum needs of the poorest people all over the world' (Singh 1977, 109). Each claim made as part of the NIEO could have been claimed as an international duty to realize the human right to health, and perhaps the mention of the NIEO in the Declaration of Alma Ata should be perceived as such.

The NIEO agenda attracted broad support from NGOs in powerful states, notably in the United Kingdom (O'Sullivan 2015). By the time of the Declaration of Alma Ata, however, the 'narrow and specific window of geopolitical opportunity' for the NIEO was already closing (Gilman 2015, 1). In 1979 Walsh and Warren proposed replacing PHC with selective PHC, as an 'interim strategy'. Their argument was that too many countries were unable to afford PHC as set out in the Declaration of Alma Ata (Walsh and Warren 1979). UNICEF, WHO's main partner in supporting PHC, soon embraced selective PHC, with resource scarcity as the main rationale. According to Packard (2016), Executive Director James Grant of UNICEF was a 'surprising' advocate of selective PHC considering his earlier career and statements. However, 'Grant was impatient. He refused to sit by and watch millions of children die from preventable deaths while the world built effective primary health-care systems' (Packard 2016, 257).

Thus, if we examine the health for all strategy for concrete measures claimed by NGOs based in powerful states and articulated in the name of the human right to health, we find few. The claim that comes closest to what HIV/AIDS activists claimed is the NIEO, but it is difficult to call that a concrete measure. Nevertheless, it would be

an exaggeration to attribute the failure of the Alma Ata movement—in terms of influencing global health politics—to this reason alone. In 1978 the Cold War continued to influence human rights discourse, whereas HIV/AIDS activists arguably benefitted from the optimism of the post–Cold War period. While the global HIV/AIDS response started against the backdrop of growth in the world economy, the Declaration of Alma Ata came just before the 1979 oil crisis, which triggered a debt crisis and global recession (Chan 2008). And while the global AIDS response benefitted from fear among powerful states that the disease could evolve into a global security threat (Lisk 2010), the Health for All strategy did not. However, if we understand the human right to health as an 'emergent right' (Chapman 2016) and the international duties it entails as 'far from settled' (Tobin 2012), and if we understand human rights as potential levers for civil society, not as a force in itself, then we can conclude that the lack of concrete claims hindered the traction of the health for all strategy.

Universal Health Coverage, the Right to Health, and Global Health Politics

The *World Health Report: Primary Health Care (Now More Than Ever)* signalled WHO's return to the aspirations of the Declaration of Alma Ata (WHO 2008; Chan 2008). This report introduced the concept of UHC to a wider audience. WHO presented UHC as 'a practical expression of the concern for health equity and the right to health' (WHO 2012).

Not everyone agrees. According to Birn, Pillay, and Holt (2017, 500), 'UHC—unless explicitly focused on public health care systems strengthening—is a misguided approach, justified by certain legitimate concerns around catastrophic health spending, but offering the likelihood of large-scale rapacious health care system penetration by—and channelling of resources to—private interests that reinforce health care system inequity and stratification'. We have argued that UHC could be the practical expression of the right to health if national and international responsibilities are clearly articulated (Ooms et al. 2014). Thus far, they are not. UHC is most often presented as a domestic technical and financial challenge (WHO 2016), which means that UHC 'as is' is unlikely to influence global health politics.

Furthermore, some of UHC's strongest supporters among NGOs based in high-income countries—assumed to be the most influential when it comes to global health politics—have made an explicit choice to focus on domestic resource mobilization rather than international financing. In a collective blog, representatives of Save The Children, PAI, and Global Health Advocates (Wright et al. 2016) argue for 'a paradigm shift towards domestic resource mobilisation (DRM)'. Their main arguments are that '[a]id budgets [are] unreliable and often restricted to donor priorities, are now stagnating or reducing.' They commit to and invite others to take a '75:25 DRM Pledge': 'We call for the UHC2030 meeting and the events happening worldwide for UHC Day to dedicate at least 75 percent of their time and attention to national domestic resources.'

While we sympathize with the arguments, we fear that if only 25 percent of the time and energy spent on UHC in international fora will focus on the global health politics of UHC, UHC may follow the same path as PHC: national or domestic resource constraints will be used as the argument to advocate for *selective* UHC. The right to health could be an important lever for increasing domestic resource allocation, but if NGOs based in high-income countries fail to use the right to health to demand their governments contribute to international financing, the argument will have reduced value for their NGO counterparts in low- and middle-income countries. Furthermore, international financing will not come to a halt; it will continue to be used for the priorities of the states providing it (for infectious disease control, as realists would predict).

Conclusion

Looking for a norm to which all or a majority of states will adhere or could adhere, and that could convince them to steer global health politics beyond the narrow self-interests of the most influential states, the right to health seems an obvious candidate. It is enshrined in treaties that the vast majority of states have signed and ratified. However, there are serious obstacles to using the right to health in that way. First, although human rights are said to be rights everyone has by virtue of being a human being, the original concept was intended to describe rights people have by virtue of being citizens of given societies. The understanding and acceptance of international duties is still in its infancy (Vandenhole 2015). Second, the right to health is an entitlement right; it is shorthand for a basket of freedoms and entitlements, but that basket is filled with mostly entitlements. Accepting international duties for human rights entitlements comes with a cost for wealthier states, and they are reluctant to accept that cost. Third, human rights work as a lever, not as a force; their power depends on how they are being used by civil society organizations. Global HIV/AIDS activism successfully used the right to health to make influential states adopt concrete measures: allowing low- and middle-income countries to purchase generic medicines, generating an international funding stream, and making the World Bank and the IMF accept increased public expenditure. In contrast, the Alma Ata movement did not demand concrete measures from the international community, as it was focused on domestic responsibility. If one wants to use the right to health as a lever for global health politics that enable UHC, one of the main challenges will be to build a coalition of civil society organizations around concrete measures.

References

Baker, Brook K. 2010. ‘The Impact of the International Monetary Fund’s Macroeconomic Policies on the AIDS Pandemic.’ *International Journal of Health Services* 40 (2): 347–363. doi:**https://doi.org/10.2190/HS.40.2.p**.

Find this resource:

Barnard, David. 2002. ‘In the High Court of South Africa, Case No. 4138/98: The Global Politics of Access to Low-Cost AIDS Drugs in Poor Countries.’ *Kennedy Institute of Ethics Journal* 12 (2): 159–174. doi:**https://doi.org/10.1353/ken.2002.0008**.

Find this resource:

Birn, Anne-Emmanuelle, Yogan Pillay, and Timothy H. Holt. 2017. *Textbook of Global Health*. 4th ed. Oxford: Oxford University Press.

Find this resource:

Brier, Jennifer. 2009. *Infectious Ideas: U.S. Political Responses to the AIDS Crisis*. Chapel Hill: University of North Carolina Press.

Find this resource:

Chan, Margaret. 2008. ‘Return to Alma-Ata.’ *The Lancet* 372 (9642): 865–866. doi:**http://dx.doi.org/10.1016/S0140-6736(08)61372-0**.

Find this resource:

Chapman, Audrey R. 2016. *Global Health, Human Rights and the Challenge of Neoliberal Policies*. Cambridge, UK: Cambridge University Press.

Find this resource:

Correa, Carlos M. 2000. *Intellectual Property Rights, the WTO and Developing Countries: The TRIPS Agreement and Policy Options*. London: Zed Books.
Find this resource:

Eide, Asbjorn. 2001. 'Economic, Social and Cultural Rights as Human Rights.' In *Economic, Social and Cultural Rights: A Textbook*, 2nd ed., edited by Asbjorn Eide, Catarina Krause, and Allan Rosas, 9–28. Dordrecht: Martinus Neihoff Publishers.
Find this resource:

Forman, Lisa, Donald C. Cole, Gorik Ooms , and Merrick Zwarenstein. 2012. 'Human Rights and Global Health Funding: What Contribution Can the Right to Health Make to Sustaining and Extending International Assistance for Health?' *Global Health Governance* 6 (1). **http://blogs.shu.edu/ghg/files/2012/12/VOLUME-VI-ISSUE-1-FALL-2012-Human-Rights-and-Global-Health-Funding-What-Contribution-Can-the-Right-to-Health-Make-to-Sustaining-and-Extending-International-Assistance-for-Health_-.pdf**.
Find this resource:

Forman, Lisa, Gorik Ooms Audrey Chapman, Eric Friedman, Attiya Warris, Everaldo Lamprea, and Moses Mulumba. 2013. 'What Could a Strengthened Right to Health Bring to the Post-2015 Health Development Agenda? Interrogating the Role of the Minimum Core Concept in Advancing Essential Global Health Needs.' *BMC International Health and Human Rights* 13: 48. doi:10.1186/1472-698X-13-48.
Find this resource:

Forsythe, David P. 2006. *Human Rights in International Relations*. 2nd ed. Cambridge, UK: Cambridge University Press.
Find this resource:

Galvão Jane. 2005. 'Brazil and Access to HIV/AIDS Drugs: A Question of Human Rights and Public Health.' *American Journal of Public Health* 95 (7): 1110–1116. doi: 10.2105/AJPH.2004.044313.
Find this resource:

Gervais, Daniel J. 2012. *The TRIPS Agreement: Drafting History and Analysis*. 4th ed. London: Sweet & Maxwell.
Find this resource:

Geuss, Raymond. 2001. *History and Illusion in Politics*. Cambridge, UK: Cambridge University Press.
Find this resource:

Gilman, Nils. 2015. 'The New International Economic Order: A Reintroduction.' *Humanity: An International Journal of Human Rights, Humanitarianism, and Development* 6 (1): 1–16.
Find this resource:

Griffin, James. 2008. *On Human Rights*. Oxford: Oxford University Press.
Find this resource:

Hafner-Burton, Emilie M., and Kiyoteru Tsutsui. 2005. 'Human Rights in a Globalizing World: The Paradox of Empty Promises.' *American Journal of Sociology* 110 (5): 1373–1411.
Find this resource:

Hunt, Lynn. 2007. *Inventing Human Rights: A History*. New York: W. W. Norton.

Find this resource:

Individual Members of the Faculty of Harvard University. 2001. ‘Consensus Statement on Antiretroviral Treatment for AIDS in Poor Countries.’ April 4.
http://www.cid.harvard.edu/cidinthenews/pr/consensus_aids_therapy.pdf.

International Conference on Primary Health Care. 1978. ‘Declaration of Alma-Ata.’
http://www.who.int/publications/almaata_declaration_en.pdf.

International Task Force on Global Public Goods. 2006. ‘Meeting Global Challenges: International Cooperation in the National Interest.’ International Task Force on Global Public Goods.
Find this resource:

Institute for Health Metrics and Evaluation. 2017. *Financing Global Health 2016: Development Assistance, Public and Private Health Spending for the Pursuit of Universal Health Coverage*. Seattle: IHME.
Find this resource:

Ishay, Micheline R. 2008. *The History of Human Rights: From Ancient Times to the Globalization Era*. Berkeley: University of California Press.
Find this resource:

Katzenstein, Peter J., Robert O. Keohane, and Stephen D. Krasner. 1999. ‘International Organization and the Study of World Politics.’ In *Exploration and Contestation in the Study of World Politics*, edited by Peter J. Katzenstein, Robert O. Keohane, and Stephen D. Krasner, 5–46. Cambridge, MA: The MIT Press.
Find this resource:

Laing, Richard, Brenda Waning, Andy Gray, Nathan Ford, and Ellen ‘t Hoen. 2003. ‘25 Years of the WHO Essential Medicines Lists: Progress and Challenges.’ *The Lancet* 361 (9370): 1723–1729.
doi:**http://dx.doi.org/10.1016/S0140-6736(03)13375-2**.
Find this resource:

Lisk, Franklyn. 2010. *Global Institutions and the HIV/AIDS Epidemic: Responding to an International Crisis*. London: Routledge.
Find this resource:

Mann, Jonathan M, 1999. ‘Human Rights and AIDS: The Future of the Pandemic.’ In *Health and Human Rights: A Reader*, edited by Jonathan M. Mann, Sofia Gruskin, Michael A. Grodin, and George J. Annas, 216–226. New York: Routledge.
Find this resource:

Martin, Lisa L. 1999. ‘The Political Economy of International Cooperation.’ In *Global Public Goods: International Cooperation in the 21st Century*, edited by Inge Kaul, Isabelle Grunberg, and Marc Stern, 51–64. Oxford: Oxford University Press.
Find this resource:

McInnes, Colin, and Kelley Lee. 2012. *Global Health & International Relations*. Cambridge, UK: Polity.
Find this resource:

O'Neill, Onora. 1996. *Towards Justice and Virtue: A Constructive Account of Practical Reasoning*. Cambridge, UK: Cambridge University Press.
Find this resource:

Ooms , Gorik , Laila A. Latif, Attiya Waris, Claire E. Brolan, Rachel Hammonds, Eric A. Friedman, Moses Mulumba, and Lisa Forman. 2014. 'Is Universal Health Coverage the Practical Expression of the Right to Health Care?' *BMC International Health and Human Rights* 14 (3). doi:10.1186/1472-698X-14-3.
Find this resource:

O'Sullivan, K. 2015. 'The Search for Justice: NGOs in Britain and Ireland and the New International Economic Order, 1968–82.' *Humanity: An International Journal of Human Rights, Humanitarianism, and Development* 6 (1): 173–187.
Find this resource:

Packard, Randall M. 2016. *A History of Global Health*. Baltimore, MD: Johns Hopkins University Press.
Find this resource:

Piot, Peter. 2015. *AIDS Between Science and Politics*. New York: Columbia University Press.
Find this resource:

Piot, Peter, Henri Taelman, Kapita Bila Minlangu, N. Mbendi, K. Ndangi, Kayembe Kalambayi, Chris Bridts, Thomas C. Quinn, Fred M. Feinsod, Odio Wobin, P. Mazebo, Wim Stevens, Sheila Mitchell, and Joseph B. McCormick. 1984. 'Acquired Immunodeficiency Syndrome in a Heterosexual Population in Zaire.' *The Lancet* 324 (8394): 65–69. doi:**https://doi.org/10.1016/S0140-6736(84)90241-1**.
Find this resource:

Rowden, Rick. 2013. *The Deadly Ideas of Neoliberalism: How the IMF Has Undermined Public Health and the Fight against AIDS*. London: Zed Books.
Find this resource:

Shue, Henry. 1996. *Basic Rights: Subsistence, Affluence, and U.S. Foreign Policy*. 2nd ed. Princeton, NJ: Princeton University Press.
Find this resource:

Singh Jyoti Shankar. 1977. *A New international Economic Order: Toward a Fair Redistribution of the World's Resources*. New York: Praeger.
Find this resource:

Smith, Raymond A., and Patricia D. Siplon. 2006. *Drugs into Bodies: Global AIDS Treatment Activism*. Westport, CT: Praeger.
Find this resource:

Solar, Orielle, and Alec Irwin. 2006. 'Social Determinants, Political Contexts and Civil Society Action: A Historical Perspective on the Commission on Social Determinants of Health.' *Health Promotion Journal of Australia* 17 (3): 180–185.
Find this resource:

Souteyrand, Yves P., Veronique Collard, Jean Paul Moatti, Ian Grubb, and Teguest Guerma. 2008. 'Free Care at the Point of Service Delivery: A Key Component for Reaching Universal Access to HIV/AIDS Treatment in Developing Countries.' *AIDS* 22 (supp. 1): S161–S168. doi:10.1097/01.aids.0000327637.59672.02.
Find this resource:

Stahn, Carsten. 2007. 'Responsibility to Protect: Political Rhetoric or Emerging Legal Norm.' *American Journal of International Law* 101 (1): 99–120. doi:**http://www.jstor.org/stable/4149826**.
Find this resource:

Stiglitz, Joseph E. 2008. 'Making Globalisation Work—The 2006 Geary Lecture.' *Economic and Social Review* 39 (3): 171–190. doi:**https://doi.org/10.7916/D8X63XS3**.
Find this resource:

Tobin, John. 2012. *The Right to Health in International Law*. Oxford: Oxford University Press.
Find this resource:

UNAIDS and OHCHR. 2006. 'The International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version. Guideline 6.' **http://www.ohchr.org/Documents/Publications/HIVAIDSGuidelinesen.pdf**.

United Nations Committee on Economic, Social and Cultural Rights. 2000. 'General Comment No. 14: The Right to the Highest Attainable Standard of Health.' UN Doc. No. E/C.12/2000/4.
http://www.unhchr.ch/tbs/doc.nsf/%28symbol%29/E.C.12.2000.4.En.

Vandenhole, W. 2015. *Challenging Territoriality in Human Rights Law: Building Block for a Plural and Diverse Duty-Bearer Regime*. London: Routledge.
Find this resource:

Vincent, R. J. 1986. *Human Rights and International Relations*. Cambridge, UK: Cambridge University Press.
Find this resource:

Walsh, Julia, and Kenneth S. Warren. 1979. 'Selective Primary Health Care: An Interim Strategy for Disease Control in Developing Countries.' *New England Journal of Medicine* 301 (18): 967–974. doi:10.1056/NEJM197911013011804.
Find this resource:

Wendt, Alexander. 1999. *Social Theory of International Politics*. Cambridge, UK: Cambridge University Press.
Find this resource:

Wolff, Jonathan. 2012. *The Human Right to Health*. New York: W. W. Norton.
Find this resource:

World Health Organization (WHO). 1981. *Global Strategy for Health for All by the Year 2000*. Geneva: World Health Organization. **http://whqlibdoc.who.int/publications/9241800038.pdf**.
Find this resource:

World Health Organization (WHO). 2008. *The World Health Report 2008 – Primary health care (now more than ever)*. Geneva: World Health Organization. **http://www.who.int/whr/2008/en/**.
Find this resource:

World Health Organization (WHO). 2012. *Positioning Health in the Post-2015 Development Agenda*. Geneva: World Health Organization. **http://www.who.int/topics/millennium_development_goals/post2015/WHOdiscussionpaper_October2012.pdf**.

Find this resource:

World Health Organization (WHO). 2016. *Public Financing for Health in Africa: from Abuja to the SDGs*. Geneva: World Health Organization. **http://apps.who.int/iris/bitstream/10665/249527/1/WHO-HIS-HGF-Tech.Report-16.2-eng.pdf**.

Find this resource:

Wright, S., A. Childs Graham, and B. Rivalan. 2016. 'To Achieve UHC, We Need to Focus on Domestic Resources.' **https://blogs.savethechildren.org.uk/2016/12/35999/**.

Gorik Ooms

Gorik Ooms, Professor of Global Health Law & Governance, London School of Hygiene & Tropical Medicine

Rachel Hammonds

Rachel Hammonds, Faculty of Law, University of Antwerp, Belgium