

The Foundations of a Human Right to Health: Human Rights and Bioethics in Dialogue

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Abstract

Human rights, including the right to health, are grounded in protecting and promoting human dignity. Although commitment to human dignity is a widely shared value, the precise meaning and requirements behind the term are elusive. It is also unclear as to how a commitment to human dignity translates into specific human rights, such as the right to the highest attainable standard of health, and delineates their scope and obligations. The resulting lack of clarity about the foundations of and justification for the right to health has been problematic in a number of ways. This article identifies the strengths of and some of the issues with the grounding of the right to health in human dignity. It then examines ethical and philosophical expositions of human dignity and several alternative foundations proposed for the right to health, including capability theory and the work of Norman Daniels, to assess whether any offer a richer and more adequate conceptual grounding for the right to health.

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Introduction

Human rights, including the right of everyone to enjoy the highest attainable standard of physical and mental health, are grounded on protecting and promoting human dignity. Although commitment to human dignity is a widely shared value, the precise meaning and requirements behind the term are elusive. As Yechiel Michael Barilan comments,

Some words are ubiquitous, important, intuitively grasped by everyone, and yet they lack clear definitions. Love, hope, justice, and friendship are such words. Human dignity belongs to this group as well.¹

The lack of clarity about the foundations of and justification for the right to health has been problematic in a number of ways. The failure to provide a stronger conceptual foundation and more comprehensive theoretical exposition for the right to health linked to that foundation has complicated efforts to reach a consensus about the normative content, scope, and requirements of the right.² It has also hindered efforts by some judiciaries to interpret the right. In addition, the incomplete theoretical framework complicates efforts to set priorities for implementation of the components of the right to health in the frequent situations when lack of resources requires doing so.

A number of commentators on the right to health from outside the field, primarily philosophers, including several who are sympathetic to human rights, have also raised issues about the formulation and interpretation of the right to health. The philosopher Norman Daniels acknowledges that a rights-based approach has several great strengths: it establishes specific governmental accountabilities for promoting population health; it addresses a broad range of environmental, legal, cultural, and social determinants of health; it emphasizes the importance of setting specific goals and targets for achieving the rights that bear on health and also monitors and evaluates progress toward these goals;

it insists on good governance; and it stresses the need for transparency and participation in efforts to secure the right.³ Nevertheless, Daniels believes the absence of a proper philosophical foundation, the lack of a theory of justice, and the failure to address priority setting make the right to health less meaningful.⁴ He explains that:

Rights are not moral fruits that spring from bare earth, fully ripened, without cultivation. Rather, we may claim a right to health or health care only if it can be harvested from an acceptable general theory of distributive justice or from a more particular theory of justice for health and health care.⁵

Other philosophers and ethicists have raised similar issues. Jennifer Prah Ruger, concerned that the foundation for the right to health lacks a systematic philosophical grounding, comments: “One would be hard pressed to find a more controversial or nebulous human right than the right to health.”⁶ According to Sridhar Venkatapuram, the grounding of human rights in legal instruments, rather than in some general ethical theory, leaves health rights unable to show how the idea of rights can be coherent in the context of limited resources.⁷

This article identifies some of the limitations in the current grounding of the right to health in human dignity. It then examines ethical and philosophical expositions of human dignity and alternative foundations for the right to health to assess whether any offer a richer and more adequate conceptual foundation. The final section of the paper focuses on what I think is the most promising of the bioethical theories, Norman Daniels’ effort to develop a comprehensive theory of justice for health and how he relates his theory to a rights-based approach as articulated in his 2008 book *Just Health: Meeting Health Needs Fairly*.⁸

Human dignity and human rights

The Universal Declaration of Human Rights (UDHR) recognizes the inherent dignity and the equal and inalienable rights of all persons as the grounding for all human rights.⁹ However, it does not conceptualize human dignity or identify the manner in which human dignity translates into specific human rights. This claim of inherent human dignity is generally taken to reflect the Kantian notion that dignity is the inviolable property of all human beings.¹⁰ Because human rights are predicated on the intrinsic value and worth of all human beings, they are considered to be universal, vested in all persons regardless of their country of origin, gender, race, nationality, age, economic status, or social position. Their inherent and inalienable nature also means they can never be lost. This insistence on the universality and inalienability of human dignity, and thus the rights that follow from the need to protect and promote human dignity, is one of the significant contributions of the human rights paradigm.

Neither the text of the UDHR nor the subsequent human rights instruments based on the UDHR identify the source(s) of human dignity or explicitly conceptualize it. Apparently, the drafters realized they could achieve consensus around the statement that all human beings are born equal in dignity and rights but not around its foundation and implications. The goal at that point in history was to reach a political agreement that atrocities inflicted on large populations, as had occurred during World War II, would not be tolerated by the international community.¹¹ The appeal to the idea of dignity arose during the drafting process precisely because of its capacity to be used as a linguistic symbol that could represent a variety of perspectives and thereby justify a political agreement on seemingly shared ground.¹² Subsequently, the lack of fixed content associated with human dignity facilitated the formulation of specific rights and duties that were legislated in the name of human dignity because doing so did not require modifying or compromising basic beliefs. The rights and duties enumerated in each human rights instrument reflect the needs identified and

the political agreement achieved at the time of drafting unrelated to an underlying conception of human dignity.¹³

The intrinsic meaning of dignity in human rights documents is left to an intuitive understanding or an assumed shared understanding. However, in 21st century societies, individuals, groups, and communities hold a diversity of worldviews, social and religious values, and cultural understandings that inform and shape their interpretations of human dignity. Referencing human dignity without further explication implies a level of social or ethical consensus that simply does not exist.¹⁴ Given this situation, there is the distinct possibility that the term human dignity conveys a multiplicity of understandings and it may even be interpreted very differently by various people. This plurality of potential connotations also characterizes the relationship between human dignity and health.

Beyond the narrowest questions of excruciating pain, though, in the realm of health, the conditions necessary for a life of dignity do not constitute an absolute and universal idea but rather are necessarily dependent on 'historical, cultural and even individual contexts.'¹⁵

Relying on an intuitive meaning may work up to a point when human dignity serves as the symbolic grounding for specific rights, but it can be problematic when human dignity is put forward as a standard to evaluate conduct or policies. For example, the Universal Declaration on the Human Genome and Human Rights emphasizes that genetic research and applications should fully respect human dignity, freedom, and rights. The Declaration further stipulates that practices contrary to human dignity—such as reproductive cloning of humans—should not be permitted, but it does not explain how those practices are to be identified or the ways in which reproductive cloning are inimical to human dignity.¹⁶ Similarly, the 1997 Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine makes a commitment to protect the dignity and identity of all human beings

and to guarantee respect for their fundamental freedoms with regard to the application of biology and medicine.¹⁷ Recognizing the need for medical research on humans, the Convention stipulates limitations to protect human dignity, particularly the types of permissible interventions altering the human genome.¹⁸ It also prohibits the creation of human embryos for research purposes.¹⁹ Again, the rationale and connection with the protection of human dignity is unclear.

Human dignity and the right to health in the ICESCR

Like other human rights instruments, the preamble of the International Covenant on Economic, Social and Cultural Rights (ICESCR), the central document which recognizes the right to health, links the rights enumerated therein with human dignity: its wording is “Recognizing that these rights derive from the inherent dignity of the human person,” but again without explaining how or why health, or, for that matter, any other rights identified in the Covenant, arises from human dignity.²⁰ General Comment 14, the seminal interpretation of the right to health by the United Nations Committee on Economic, Social and Cultural Rights, also fails to provide an exposition for human dignity or a theoretical foundation for the right. Article 1 of the General Comment relates health to human dignity, but in a manner that establishes human dignity more as a goal of the right. It states: “every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity.”²¹ Human dignity is therefore identified both as the foundation and the objective of the right to health. The text of the General Comment does not go on to explain how or why health is associated with human dignity or is of special moral importance. It merely mentions that the human right to health is recognized in numerous international instruments. Article 3 also links the right to health with the realization of other human rights, including the right to human dignity, suggesting that human dignity is an independent right and not the foundation of other human rights.

Some legal analysts consider the failure to provide a more comprehensive theoretical foundation for the right to health as largely irrelevant. Roberto Adorno points out that the international human rights instruments are not philosophical treatises aimed at discerning truth, but political statements resulting from compromise.²² John Tobin, also writing from a legal perspective, rejects the need for a comprehensive theory to ground the right to health.²³ Using a term first coined by Cass Sunstein, Tobin characterizes the international legal instruments which recognize the right to health as examples of “incompletely theorized agreements.”²⁴ The concept of an incompletely theorized agreement describes a process by which a consensus is reached on an issue in circumstances where there is disagreement on the reasons or principles that justify the agreement.²⁵ According to Tobin, the concept of incompletely theorized agreements is well suited to capture the nature of international human rights instruments, which “must accommodate a moral universe that is diverse and pluralistic, and allow for agreement between states without the need to adhere to a particular theory of general principles.”²⁶ He understands this process as enabling states to agree on the inclusion of the right to health and other rights within international treaties as a moral interest worthy of recognition without formal agreement on the principles or theory underlying the right. Tobin contends that what matters is that there is an overlapping consensus with respect to the values that underlie the right: the worth of the individual, the need to respect this worth, and the role of the state in securing the worth of individuals. He understands this overlapping consensus to be sufficient to make the right to the highest attainable standard of health a moral entitlement and the means to respect, protect, and fulfill the moral value of every person.²⁷

As noted above, the failure to conceptualize human dignity and explain how it serves as the foundation for specific rights, like the right to health, or to provide another grounding along with human dignity, make it difficult to conceptualize the scope of the right and the associated obligations of states related to its implementation. Tobin acknowledges that the status of the right to health as an incompletely

theorized agreement and the differences among States on the principles underlying the right have militated against the prospect of achieving detailed agreement as to the specific measures required for implementation of the right to health.²⁸

This situation has particularly left the evolving and expansive interpretation of the right to health adopted in General Comment 14 vulnerable to criticism. In particular, the inclusion of the socio-economic determinants of health has been treated as illegitimate because it goes beyond the components of the right enumerated in the outdated conception of the right to health in Article 12 of the ICESCR.²⁹

Human dignity in philosophy, theology and bioethics

Concepts of human dignity reach back to the seminal writings of Immanuel Kant and arguably can even be found in the Stoic tradition of ancient Greece and Rome. In his overview of the uses of human dignity in bioethics, Adam Schulman, editor of a collection of essays commissioned by the US President's Council on Bioethics, identifies four strands or sources: (1) the classical notion of dignity as something rare and exceptional and therefore worthy of honor and esteem; (2) the biblical account of persons as "made in the image of God" and therefore possessing an inherent and inalienable dignity; (3) Kantian moral philosophy's identification of human dignity with rational autonomy along with its emphasis on equal respect for all persons and never treating another person as a means to an end; and (4) 20th century constitutions and international human rights declarations that cite human dignity as the supreme value on which all human rights and duties are said to depend.³⁰

O. Carter Snead proposes that a useful way to divide the various approaches to human dignity is to distinguish between those that regard dignity as a contingent standard of valuation and those that treat human dignity as an intrinsic attribute of human beings. Using this distinction, it is noteworthy that the concept of dignity first emerged in classical antiquity, where dignity was reserved for exceptional persons exhibiting special qualities of

human excellence. In later centuries, a contingent notion of dignity was also applied in an aristocratic sense related to social standing or rank.³¹ This contingent notion of human dignity lends itself to invidious distinctions between one human being and another.³² It also raises questions as to what it is about particular people that warrants special admiration.³³

An aristocratic conception of human dignity has contemporary analogues in the interpretation of human dignity held by the transhumanists and, more broadly, others who advocate human enhancement. Nick Bostrom, a leading transhumanist theorist, puts forward the idea of dignity "as a quality, a kind of excellence admitting of degrees and applicable to entities both within and without the human realm."³⁴ For Bostrom, dignity as a quality in human beings (or for that matter, intelligent machines) functions as a virtue or an ideal which can be cultivated, fostered, respected, admired, or promoted.³⁵ The transhumanist project advocates the enhancement of human beings, including through integrating or attaching non-biological entities, and assumes doing so will also enhance human dignity. Proponents argue that individuals should have the right to transform their own bodies as they wish and that parents should have the right to decide which technologies to use when deciding to have children.³⁶ In contrast, those holding a more traditional human rights perspective on human dignity, like myself, anticipate that the use of human enhancement technologies could undermine our humanness and by doing so, our dignity as humans. Another consideration is that access to any of these technologies is likely to be limited to those having the financial means to do so, with the result that benefits would not be widely shared, and this would likely introduce even greater economic and social inequalities within and between societies. Enhancement interventions might also introduce invidious distinctions between persons who are "improved" and those in a natural or "unimproved" state, thus violating the fundamental human rights principle of non-discrimination and non-stigmatization.³⁷

Like human rights, two of Schulman's strands consider human dignity to be an intrinsic attribute of all persons. Biblical religion contributes the Judeo-Christian scriptural reference to man (humans) "as made in the image of God." The implication is that human beings therefore possess an inherent and inalienable dignity. One dimension of this dignity, as portrayed in the Book of Genesis, is the special position of human beings in the order of creation: humans are given stewardship or dominion over all things. Schulman's interpretation of this central passage points in another and humbler direction: the reminder that while humans are made in God's image, we are not ourselves divine; we are creatures, not creators.³⁸ Gilbert Meilaender tries to capture something of this dichotomy when he characterizes the human person as "neither beast nor God" and links human dignity with the acceptance of this in-between status.³⁹ An emphasis on the respect for others based on their having been created in the image of God finds expression in both the Jewish and Christian ethical traditions.⁴⁰ However, we live in a secular society with a wide diversity of religious affiliations, and in which many people hold a secular outlook, so that many people are uncomfortable with citing any religious texts and fear the imposition of religious dogma.⁴¹

Kantian moral philosophy signifies a significant break with hierarchical or contingent notions of human dignity. Kant's formative contribution was to conceptualize dignity as the intrinsic worth belonging to all human beings by virtue of the capacity of rational beings to reason their way towards, and then to abide by, the moral law and thereby to participate in a moral community. In his writing, he states that this capacity for moral reasoning and moral conduct underlies the claim of every human being to receive respect from his fellow human beings and the requirement to give then respect in turn.⁴² Kant's ethics was based on what he termed the Categorical Imperative. He formulated the Categorical Imperative in several different versions, the two most relevant of which are the Formula of the Universal Law ("Act only on that maxim through which you can at the same time will that it should become a universal law") and the

Formula of the End in Itself ("Act in such a way that you always treat humanity, whether in your own person or in the person of any other, never simply as a means, but always at the same time as an end").⁴³ Because Kant located human dignity entirely in rational autonomy, i.e., the capacity to make moral decisions, he has been criticized for denying significance to other aspects of our humanity. His formulation also raises questions as to the status of human beings who do not yet have the powers of rational autonomy (infants and children), who can never obtain them (those with cognitive mental impairment), or who have lost them (those with dementia).⁴⁴ Another problem is that the doctrine of rational autonomy can be difficult to apply, especially in a biomedical context.⁴⁵ Schulman also faults Kant's moral philosophy with bequeathing a "deplorable legacy" in the form of a rigid dichotomy between a morality of absolute imperatives (deontology) as Kant advocated and one that considers the results of our actions (consequentialism).⁴⁶

There are many prominent Kantians in contemporary philosophical and legal circles writing on human dignity and Kant's deontological approach also informs much of modern human rights. Stephen Malby identifies Alan Gewirth, Deryck Beyleveld, and Roger Brownsword as Kantian theorists writing on human rights who associate human dignity with the capacity for autonomous moral choice.⁴⁷

Capabilities approach

Several bioethicists have suggested that a capabilities approach could offer a more fully developed grounding for a right to health. According to Jennifer Prah Ruger, the health capability paradigm offers a philosophical justification for the right to health and makes a case for the right as a meaningful and operational right.⁴⁸ But as the analysis below indicates, capability theory has thus far failed to do so.

Of the current exponents of a capabilities approach, Martha Nussbaum's work, perhaps the best known, combines human need and dignity

across cultural differences as its foundation.⁴⁹ However, Nussbaum does not offer a clearly articulated conception of human dignity. For Nussbaum, human dignity is an “intuitive idea.”⁵⁰

She conceptualizes human capabilities as “what people are actually able to do and to be” and as a measure of the extent they can live a life that is worthy of the dignity of the human being. According to Nussbaum, “The basic intuitive idea of my version of the capabilities approach is that we begin with a conception of the dignity of the human being, and of a life that is worthy of that dignity.”⁵¹ As in a human rights approach, she holds that all persons possess full and equal human dignity by virtue of their common humanity. She explicitly includes children and adults with severe mental disabilities. Nussbaum usefully distinguishes between the human dignity inherent in all persons and respect for that dignity. She argues that the absence of opportunities for the development and exercise of major human capacities can result in a life unworthy of human dignity.⁵² Although human beings have a worth that is inalienable because of their capacities for various forms of activity and striving, these capabilities must be nurtured for their full development and their conversion into actual functioning. According to Nussbaum, the equal worth of all persons confers political entitlements for the development of their capabilities. These political entitlements constitute the basic social minimum governments should provide for their citizens.⁵³ The social goal should be understood in terms of the government getting citizens above the capability threshold needed for a meaningful life.⁵⁴

Nussbaum identifies a list of 10 human capabilities central to human flourishing. Her list does not ascribe human dignity to any single characteristic or basic capability, as for example the Kantian emphasis on rationality, which would have the disadvantage of excluding from human dignity many human beings with severe mental disabilities. Also, her list of capabilities captures wide dimensions of human needs and behavior, to reference such things as senses, imagination, and thought, emotions, affiliation, and relationships

with other species that are necessary for human flourishing. Nussbaum’s delineation of central human functional capabilities includes three with health-related implications:

- *Life*: being able to live to the end of a human life of normal length, i.e., not dying prematurely or having a life so reduced as to be not worth living;
- *Bodily health*: being able to have good health, including reproductive health, to be adequately nourished; and to have adequate shelter;
- *Bodily integrity*: being able to move freely from place to place; to be secure against assault, including sexual assault and domestic violence; having opportunities for sexual satisfaction and for reproductive choice.⁵⁵

Aside from incorporating a more inclusive conception of human characteristics related to human dignity, including some that a government could not promote or protect, Nussbaum’s work parallels a human rights approach, with many of its theoretical limitations and few of its policy benefits. She does not explain the basis on which she has selected her 10 human capabilities. Nor does her work describe the health-related capabilities in any detail. As Venkatapuram points out, a general theory of health and social justice needs to describe what health is, how it is created and distributed, and why it is valuable to human beings. It should also be able to identify the claims and obligations individuals have in relationship to their health and the duties of other agents, including at a policy level.⁵⁶ Nussbaum’s work does not do so.

In his book *Health Justice*, Venkatapuram also uses a capabilities approach to argue for a theory of social justice that recognizes people’s moral right to the capability to be healthy and to try to identify claims individuals have in regard to their health in modern societies and the globalized world.⁵⁷ The book aims to show how a right to health can be a coherent concept grounded in the foundational values of justice.⁵⁸ Venkatapuram recognizes every human being’s moral entitlement to be healthy, or

in shorthand, a human right to be healthy. Rejecting a notion of health as the absence of disease, he understands health as a meta-capability, a cluster of inter-related and basic capabilities to be and do things. He grounds the moral entitlement in the central importance of health and longevity to human beings and the recognition that it requires social action as well as social vigilance. In his view, the social entitlement has both a negative dimension to protect people's health and longevity from socially caused harms and a positive dimension to certain social arrangements or social bases, resources, conditions, support, and assistance that would produce, promote, sustain or restore a capability to be healthy.⁵⁹ According to Venkatapuram, the capability to be healthy is a kind of freedom, which is intrinsically and instrumentally valuable and shows respect for the equal dignity of human beings. He identifies four causal categories of factors shaping the opportunity to be healthy: individual biology, physical exposures, social conditions, and individual agency.⁶⁰ In the end, though, Venkatapuram, like Nussbaum, fails to identify the content of the specific rights and obligations individuals can claim from duty holders, specifically their governments, either individually or corporately.

Ruger presents another version of a capability approach, the health capability paradigm, which offers a vision of a healthy society grounded in a commitment to freedom and human flourishing.⁶¹ In brief, her goal is a society in which all people have central health capabilities to avoid premature death and escapable or preventable morbidity. For Ruger, not just health or health care but health and the capability for health itself are moral imperatives. She writes,

There are no guarantees of good health, but society can, if it will, design and build effective institutions and social systems, structures, and practices, supporting all its members as they seek to achieve these central health capabilities.⁶²

She views her theory as a hybrid between sufficiency and priority principles. While eschewing the goal of complete equality, she believes priorities to invest

resources should be responsive to where data show shortfalls in equality, that is, greatest medical need. She acknowledges that the high cost of health care means that it will be necessary to redistribute income to enable all groups to pay for health care, but because human agency is a key component of her version of health capability, this redistribution would have to be voluntary and willingly embraced as the necessary cost of a valued enterprise. Further, because in her version of capability theory resource allocation should rest on medical necessity and medical appropriateness, not the ability to pay, Ruger believes that progressively financed universal health insurance, which is community rated to distribute risk, is essential for human flourishing. While there are attractive features of Ruger's theory, it lacks the concreteness and specificity of a human rights approach, and leaves too much to the likely wisdom of members of a society coming together in an unguided manner to make the right decisions about the distribution of health benefits.

Norman Daniels' theory of just health

I believe that Daniels' 2008 book *Just Health: Meeting Health Needs Fairly* offers the most promising philosophical and justice framework for a right to health.⁶³ *Just Health* begins with three central focal questions: (1) is health of special moral importance? (2) when are health inequalities unjust? and (3) how can we meet health needs fairly under resource limitations? He links the special moral importance of health to its impact on the range of exercisable or effective life opportunities open to us. Meeting health needs allows people to choose a life plan that their talents and skills enable them to pursue. By protecting health, we therefore contribute to the safeguarding of fair equality of opportunity.⁶⁴ In turn, various socially controllable contributions to health status and outcomes—medical services, traditional public health, and the broader social determinants of health—derive moral importance because of their impact on population health and its distribution.⁶⁵ All of this means that protecting health and the inputs to health is a social obligation:

As members of society seeking fair terms of cooperation to protect each other's health, we owe it to each other to design institutions that do that and create a collective space to protect opportunity in this way."⁶⁶

According to Daniels, this requires universal comprehensive health care, including public health, primary health care, and medical and social support services. He also extends the requirements to providing a fair distribution of the key social determinants of health.⁶⁷

Daniels' answer to his second question is that inequalities that remain after a fair distribution of socially controllable goods and factors affecting population health and its distribution, particularly the allocation of the social determinants of health, should count as acceptable or fair inequalities.⁶⁸ In stressing the importance of the social determinants of health, or what General Comment 14 refers to as the underlying determinants of health, he addresses issues that have been largely ignored in bioethics. He draws on work in public health and social medicine that health inequalities count as inequities when they are avoidable, unnecessary, and unfair, while acknowledging that there are disagreements as to what is avoidable and unfair.⁶⁹

In reference to his third question, Daniels recognizes that any decisions we make about how to distribute resources to meet health needs when the resources are not sufficient to provide all potentially beneficial preventive and curative services to everyone in the society may raise legitimacy issues. Daniels also acknowledges that his general principles of justice do not provide substantive principles for fair distribution. He therefore proposes that we rely on a fair deliberative process to reduce disagreements about resources allocation.⁷⁰ After rejecting a variety of approaches as not consistent with a fair process and that reflects the way allocation decisions are currently made—market accountability, a procedural approach to majority rule, and an empirically based cost-value methodology—he identifies and conceptualizes four requirements to meet the standard of what he terms “accountability for reasonableness.”⁷¹

These are: (1) rationales for decisions should be publicly accessible to both clinicians and patients; (2) rationales for coverage decisions should aim to provide a reasonable construal of how the organization or public agency seeks to provide value for money in meeting the health needs of a defined population; (3) there must be mechanisms for challenging decisions and resolving disputes as well as opportunities for revision and improvement of policies in light of new evidence or arguments; and (4) there is voluntary or public regulation of the process to assure that the first three conditions are met.⁷²

A recently published article on applying a human rights framework to priority setting in health offers a similar approach as Daniels. Alicia Ely Yamin and Ole Frithjof Norheim reject market-based solutions as inconsistent with a rights framework because it would signal a cultural acceptance of exclusion of the poor and it would produce substantial inequalities in access to health care and to outcome. But they also acknowledge that specific priority-setting decisions cannot be derived from transcendent principles of human rights. Instead, they opt for a process of meaningful democratic deliberation based on meaningful participation and accountability.⁷³

Daniels' chapter dealing most explicitly with human rights attempts to build on the strengths of the human rights paradigm while seeking to compensate for some of its inadequacies. He identifies the most important blind spot in the human rights framework as the lack of a basis on which to set priorities among claimants to different rights as well as to the components of a single right, but as noted above, his theory also lacks substantive principles for fair distribution in conditions of scarcity.⁷⁴ His grounding of a moral right to health and health care is the following: “If we have a social obligation to ensure fair equality of opportunity, we also have an obligation to promote normal functioning, and our moral right to health and health care is the corollary of these obligations.”⁷⁵ He acknowledges that his theory of the moral right to health does not provide a basis for the broad range of legal rights enumerated in international

agreements and believes they should emerge from broader work in political philosophy.

In addressing what we owe each other, Daniels identifies a series of social obligations to protect and promote health for all. First, because meeting health needs protects the range of opportunities people can exercise, meeting the health needs of all persons viewed as free and equal citizens (but apparently not all residents within a society) is of comparable and special moral importance. Second, according to Daniels, just health requires that we protect people's shares of the normal opportunity range by treating illness when it occurs, by reducing the risks of disease and disability before they occur, and by distributing those risks equitably. He determines that these social obligations require giving all people access to medical services that promote and restore normal functioning. He cautions that the medical system should not neglect preventive measures in favor of curative health services. As noted, he also advocates looking beyond the medical system to traditional public health measures and to the broader social determinants of health and their distribution.⁷⁶ The norm he derives is that there should be universal access, based on health needs, to those public health and personal medical services that support fair equality of opportunity taking reasonable resource constraints into account.⁷⁷

Daniels' approach has one significant limitation: it does not provide the basis for a universal human right to health or health care. Because the moral right to health he discusses is tied to the terms of fair cooperation within a specific society of free and equal individuals and to the resources available there, it only has relevance to the conditions inhering in that society and cannot be generalized beyond it.⁷⁸ According to Daniels, the specific content of the right would depend ultimately on the entitlements determined by the reasonable choices made by appropriate agents of the society, taking into account citizens' health needs to achieve normal functioning and the constraints imposed by the resources available. Daniels points out that his limitation parallels the principle of progressive realization within the confines of available resources, as well as the actual implementation of so-called universal

rights, which States parties have an obligation to "respect, protect, and fulfill" under ICESCR. The claims individuals can successfully make to receive the entitlements that are enumerated in the international human rights instruments similarly depend on the resources, including the political resources, available in those States.⁷⁹ However, the approach proposed in human rights theory of setting forth universal norms and obligations, but then assuming their implementation will depend on the resources available, has the advantage of providing more guidance for priority setting. It also recognizes that some norms are absolutes and should not be violated under any circumstances.

As required in General Comment No. 14, Daniels believes that in setting priorities across all the interventions that might improve realization of health rights, policy makers need to assess complex epidemiological, economic, technical, and other information.⁸⁰ And like a human rights approach, Daniels is sensitive to the need for disaggregation of data so as to be able to analyze which rights and which population groups would be affected, and in what kind of way, by each potential intervention. He advocates placing special attention to who benefits most and in what ways and who would be left out or disadvantaged.⁸¹ Also like a human rights-based approach, Daniels' methodology for priority setting stresses political accountability, transparency, and the gathering of appropriate evidence for an analysis of options to improve the realization of rights that impact on health, stakeholder involvement in negotiations about the goals and targets of these options, and ongoing monitoring and evaluation of the impact of policies so they may be revised if necessary.⁸² He notes the considerable work already under way by rights practitioners to develop appropriate monitoring and evaluation tools.⁸³

Nevertheless, Daniels' approach to priority setting does not fully resolve difficult priority-setting issues in the context of the limited availability of resources. Accountability for reasonableness provides a coherent rationale for a process but not sufficient detail about the principles that should inform it. Perhaps no theoretical approach could do so. However, the incorporation of additional

human rights norms, such as giving priority to the most vulnerable, would encourage an outcome more consistent with a human rights framework. It is therefore concerning that he does not propose to have mechanisms in place to attempt to give poor and vulnerable individuals and groups adequate representation in the policy-making process.

Conclusion

Although there are many interpretations of human dignity, none provides a meaningful conceptual foundation for the right to health. Hence, the option seems to be either accepting the status quo of an incompletely theorized right or providing an alternative or supplementary conceptual grounding and interpretation of the right, such as one of the varieties of capability theory or Daniels' just health theory. However, the analysis in this article of the writings of several of the philosophers whose works have been identified as potential alternatives has identified limitations in all of them. Even Daniels' just health theory, the most attractive option, does not provide a foundation for a universal right to health, and it fails to provide a theoretical basis for determining priorities for funding when needs and demands for health improvements outpace existing resources.

So where does that leave us? My preference, perhaps because I work in both the fields of bioethics and human rights and I am not trained in law, would be to incorporate elements of Daniels' theory of just health into an interpretation of the right to health. Daniels' work has many compelling features. He offers a strong philosophical rationale of the special moral importance of health, health-related institutions and services, and the social determinants of health, which would strengthen a justification for the right to health. He also sets the right to health in the framework of a theory of justice. I think there are ways to meld the universal norms set forth in the international human rights instruments enumerating a right to health and the general comments interpreting the associated obligations with the process Daniels details for determining priorities consistent with available resources. The

universal norms could function as a set of goals within which to determine priorities, as well as evaluative standards to assess progress. As Daniels observes, despite the apparent universality that comes from declaring certain rights to be universal rights, in practice the content of the rights or health-related entitlements that are implemented depend on conditions in a specific state.⁸⁴ And as noted, Daniels' claim that the moral right to health and health care can only have a specific content relative to the conditions in a specific society as to their resources and needs, delineates what progressive realization means.⁸⁵ By calling for negotiations between government officials and stakeholders to determine which interventions among the options consistent with available resources would likely have the biggest impact on health, and/or meet the most important health needs, and therefore should have priority and emphasizing the need for transparency, Daniels replaces what in many circumstances has been arbitrary decision making by government officials regarding implementation of the right to health with a meaningful participatory process.⁸⁶ At a minimum "it should clarify what we can truly expect from a right to health, moral or human."⁸⁷

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