Edited by
Nana K. Poku and Alan Whiteside

Global Health and Governance

HIV/AIDS

Third World Quarterly Series

Global Health and Governance

HIV/AIDS

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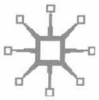

First published 2004 by
PALGRAVE MACMILLAN
Houndmills, Basingstoke, Hampshire RG21 6XS and
175 Fifth Avenue, New York, N. Y. 10010
Companies and representatives throughout the world

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ISBN 1–4039–2063–X

This book is printed on paper suitable for recycling and made from fully managed and sustained forest sources.

A catalogue record for this book is available from the British Library.

Library of Congress Cataloging-in-Publication Data

Global health and governance : HIV/AIDS / edited Nana K. Poku and Alan Whiteside.
p. cm.
Includes bibliographical references and index.
ISBN 1–4039–2063–X (cloth)
1. AIDS (Disease)--Prevention. 2. AIDS (Disease)--Social aspects. 3.World health. 4. Public health--International cooperation. I. Poku, Nana, 1971- II. Whiteside, Alan.

RA643.8.G565 2004
362.196'9792--dc22

2003058074

10 9 8 7 6 5 4 3 2 1
12 11 10 09 08 07 06 05 04 03

Printed and bound in Great Britain by
Antony Rowe Ltd, Chippenham and Eastbourne

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Contents

Global health and the politics of governance: an introduction

NANA K POKU & ALAN WHITESIDE

Some 30 new viruses—ranging from the Human Immunodeficiency Virus (HIV) to little known but equally lethal haemorraghic fevers such as Ebola—emerged during the last quarter of the twentieth century (CDC, 2001; WHO, 2000a, 200b). In many cases the source of these viruses is unknown, as is the reason for their emergence. Many of the most powerful chemotherapeutical controls have been rendered impotent at a time when too few new drugs are being developed to replace those that have either lost their effectiveness or are unsuitable for treating contemporary viruses. Crucially, these developments are taking place at a time when the World Bank and International Monetary Fund (IMF) have eclipsed the World Health Organisation (WHO) in health and social policy formulation, especially for developing countries. It is against this background that the articles in this special issue of *Third World Quarterly*, 'Global health and governance: HIV/AIDS,' seek to offer a critical and multidisciplinary appraisal of global health policies, structures and the politics of governance. Composed of original articles from leading academics engaged in or concerned with global health politics, the underlying objective is to help generate a timely debate and understanding of the impact of globalisation on health and the plight of vulnerable people. Lesley Doyal aptly summarises the nature of the project in the form of a question: 'how has the process of globalisation affected trends and well-being over the past few decades?'.

The nature of the problem

The transition from WHO to the primary institutions of global economic governance—IMF and World Bank—has been accompanied by two important changes in the global health arena: first, a significant shift away from the traditional concepts of social justice and equity in public health provision towards markets and efficiency (see the articles by Evans, Heywood and Doyal). This has given rise to a position where public health services and healthcare for all are now perceived (in policy making circles) as an obstacle threatening public finances and the wealth of nations (as Cheru explains). As a result, public health budgets are no longer seen as a productive investment for human development and economic growth but as an unnecessary financial burden on governments which should be avoided. The intensification of Structural Adjustment Programmes (SAPs) in the developing world provides a powerful reminder of this new reality. Although there are many variations of SAPs, two broad policy components have

come to characterise them all: short- to medium-term macroeconomic stabilisation measures to restore internal and external balances, which fall within the province of the IMF; and SAPs proper, which are designed to 'unleash market forces so that competition can help improve the allocation of resources ... getting price signals right and creating a climate that allows business to respond to those signals in ways that increase the returns to investment' (World Bank, 1994: 61).

Despite two decades of adjustment pressures, there are no signs that these objectives are being achieved. Lipumba observes that the dominant 'opinion among African intellectuals is that Structural Adjustment Programmes are part of the [continent's] problem rather than part of the solution' (Lipumba 1994: 32). Certainly, SAPs have done little to foster the social, political and economic conditions that could contribute to the development of stable state–society relations in the developing world and to the creation of a stable social order. Take the case of Africa: the promotion of exports for debt repayment and the cutting of public expenditure on welfare in a region where 200 million people are undernourished, where there is one doctor for 40 000 people, compared with one for 400 people in industrial countries, and where nine out of the 10 HIV infected people worldwide reside, is a scandal. One author has even referred to SAPs as a form of economic genocide. 'When compared to genocide in various periods of colonial history, its impact is devastating. Structural Adjustment Programmes directly affect the livelihood of more than 4 billion people' (Chossudovsky, 1996: 17).

Second, while we previously looked to the state to provide the legislative framework and standards of public health services, under IMF and World Bank leadership the role of the state has been replaced by a multiplicity of new—and largely unaccountable—actors in the health arena (see the articles by Thomas, Haywood and Poku). At the national level, governments the world over are actively engaged in contracting out essential services ranging from laundry and cleaning to the provision of trained medical staff for the administration and delivery of essential health services (Pollock *et al*, 1999). Public–Private Partnerships (PPPs) are also apparent at the global level and, indeed, are beginning to be recognised as potentially radical new systems of global governance (Buse & Walt, 2000; Collin *et al*, this issue). Some of these are donation programmes where pharmaceutical companies have donated particular drugs to eliminate a particular disease. The best known and longest established is the Mectizan Donation Programme, where Merck have donated ivermectin for as long as necessary to rid African countries of onchocerchiasis—river blindness. Others involve the so-called 'new philanthropists', who donate large sums of money for specific health-related projects: at the end of 1999, for example, the Melinda and Bill Gates Foundation donated $6 billion for vaccines. To put this figure into context, the entire annual budget of WHO is less than $1 billion.

Behind these successful partnerships lurks an increasing tension between the new rules, actors and markets that characterises the modern phase of globalisation and the ability of countries to protect and promote health.

Globalisation and health

The concept of globalisation has gained particular currency in both the language

and iconography of contemporary global politics. Scholte offers a minimalist definition as 'a still on-going process whereby the world is in many respects becoming one relatively borderless arena of social [and economic] life' (Scholte, 1997). Elsewhere, Robertson also notes that 'globalisation also refers to cultural and subjective matters' (namely, the scope and depth of consciousness of the world as a single place) (Robertson, 1996: 13–31). For these and other writers, even if the eventual picture remains in doubt, the principal agents of such change are evident enough, such as globalising corporations emerging from a rapid process of super-mergers, technoscientific networks and the aesthetic architects of mass culture. At the same time there is also a shrinking of the world brought about by the third technological revolution that has enabled us to travel both vicariously and instantaneously to almost all regions of the world (Allen & Hammett, 1998). In this sense the process of globalisation is tearing away the traditional notion of continuous, historical time on the one hand, and of established spatial parameters on the other. Temporal discontinuity and spatial 'deterritorialisation' displaces the familiar and the secure, placing all conventional poles of attachment in doubt and flux.

Thus, close encounters of a direct kind in which we meet others face to face are being replaced by indirect contact with remote 'others'. In short, globalisation has radically altered the manner in which we conduct our lives, in the sense that locales are thoroughly penetrated by and shaped in terms of social influences quite distant from them. Here Anthony Giddens' arguments offer insight. He argues that such changes are reconstructing social relationships across reorganised time and space. This is 'a single world, having a unitary framework of experience ... yet at the same time one which creates new forms of fragmentation and dispersal' (Giddens, 1990: 1). This condition, Giddens argues, is giving rise to a 'sequestration of experience', separating daily life from familiar poles of moral understanding. Thus, 'for many people, direct contact with events and situations which link the individual lifespan to broad issues of morality and finitude are rare and fleeting' (p 21).

While there is some question as to whether this process represents the end, or the fulfilment, of a Eurocentric modernisation, there is little question about its differential impact on people and societies across the globe. Most obviously, poverty, mass unemployment and inequality have mushroomed alongside recent advances in technological developments and the rapid expansion of trade and investment (Poku & Cheru, 2001). Moreover, the overall pattern of global resource distribution has radically shifted over the past two decades from a shape resembling an egg to a pear (Poku & Cheru, 2001). In other words fewer people have occupied the top, and more people have slipped towards the bottom. Between 1990 and 1998, for example, the share of the population in developing countries living below $1 per day fell from 29% to 24% per cent. But because of population growth, the number of people in poverty declined by only 77 million—hardly a stellar result. Interestingly, all the improvements occurred in East Asia, mainly in China. Excluding China, the number of poor people in the developing world increased by 70 million, from 916 million in 1990 to 986 million in 1998. Similarly, while the incidence of income poverty has not fallen by much over this period there are large regional variations in performance.

Based on a poverty line of $1 a day, East Asia and the Middle East and North Africa have reduced their numbers in poverty - East Asia dramatically so. But in all other regions the number of people living on less than $1 per day has risen.

Hence, despite the earth-shattering advances made by humanity in the fields of commerce, finance and technology in the past two decades or so, 30% of the world's population still live in absolute poverty. Here, poverty is defined as the inability to attain a minimum standard of living, measured in terms of a household's inability to meet its basic consumption needs or the income required to satisfy them. Gro Harlem Brundtland, the head of the WHO summarises the position in the following way: 'In other words, half the world's population do not have anything close to a decent standard of living. That means that 3 billion people live in such poverty that they can not afford proper housing, proper health care and proper education for their children' (Brundtland, 2000).

Not surprisingly, the resulting inequalities in life outcomes are stark. Those living in absolute poverty are five times more likely to die before reaching five years of age than those in higher income groups. Moreover, poverty has a woman's face (see the articles by Doyal, Baylies and Renwick). Of the 1.3 billion people defined by the WHO as the poorest—that is those surviving on less then $1 per day—only 30% are male. Poor women are often caught in a damaging cycle of cultural bias and gender discrimination that further exposes them to exploitation and disease. Take the following passage from one woman's experience in South Africa:

> My husband lost his job about five months ago. It was a big shock but we thought we could cope. I was earning a reasonably good wage. We had to cut a few corners though. We had to eat less meat. We had to save on all kinds of things ... Then two months ago I lost my job. We were desperate. There was no money coming in now ... Now they've cut off the electricity and we're two months in arrears with rent. They're going to evict us, I'm sure, we just can't pay though. My husband decided to go to Jo'burg ... I don't know where he is ... Sometimes [the children] lie awake at night crying. I know they are crying because they are hungry. I feel like feeding them Rattex. When your children cry hunger crying, your heart wants to break. It will be better if they were dead. When I think things like that I feel worse ... I'm sick. I'm sick because of the cold. I can't take my children to the doctor when they are sick because there is no money ... What can one do? You must start looking. You can also pray to God that he will keep you from killing your children (Poku, 2002).

This woman's experience shows the myriad of mechanisms through which poverty creates an environment of risk. She knows, even without necessarily understanding the statistics, that poverty is closely linked with high unemployment, hunger and malnutrition, lack of basic services, inability to pay for or access health care, disintegration of families, vulnerability, homelessness and often hopelessness. She knows that women bear a greater burden than men and that children become its most defenceless victims of all. Beyond this, poverty is also associated with weak endowments of human and financial resources, such as low levels of education, with related low levels of literacy, few marketable skills and generally poor health status (see the Whiteside and Poku articles). An aspect of this poor health status is the existence of undiagnosed and untreated Sexually

Transmitted Diseases (STDs) among the poor (WHO, 2000a). Infection with other stds is an important co-factor for transmission of such dangerous viruses as HIV; genital ulcer diseases in particular, such as chancroid, provide an effective entry point for such viruses (WHO, 2000b). Such painful bacterial STDs are relatively uncommon in rich countries because of the availability of antibiotics (Medilinks, 2000). In the developing world, however, even when poor people have access to healthcare, the clinics may have no antibiotics to treat these deadly bacterial STDs.

About the project

In broad terms, there are two major themes running through this special issue: the first deals with the changing political economy of health, with an emphasis on the increasing role of profit-making non-state actors in the provision and delivery of essential health services. Building on this, the second theme deals with arguably the most pressing public health challenge of modern times—the impact and effective governance of HIV/AIDS. Collectively, the articles addresses the power relations which drive the epidemic, frustrate the possibility of alleviation, care and recovery—and operate not just to marginalise those with HIV/AIDS, but to relegate entire continents and regions to a vulnerable and bleak future.

References

Allen, J & Hammett, C (1998) *A Shrinking World? Global Unevenness and Inequality* (Oxford: Oxford University Press).

Brundtland, GH (2000) Global Health and Population, Reith Lecture, BBC.

Buse, K & Walt, G (2000) Global public–private partnerships: part II—what are the issues for global governance?, *Bulletin of the World Health Organisation*, July.

Centers for Disease Control (CDC) http://www.cdc.gov, 20, June 2000.

Chossudovsky, M. (1996) 'SAP and Africa', *Third World Resurgence*, 74, p 17.

Giddens, A (1990) *The Consequences of Modernity* (Cambridge: Polity).

Lipumba, N. (1994) *Africa Beyond Adjustment* (Washington, DC: Overseas Development Council).

MEDILINKS, African Statistics: Cost of HIV/AIDS, Malaria & TB to Africa, http://www.medilinks.org/Features/Articles/Statistics%20in%20Africa%202001.htm.

Pollock, A. (1999) PFI and WHO, *Lancet*, 27 November.

Poku, N (2002) *AIDS in Africa: The Silent Crisis* (London: Pluto Press).

Poku, N & Cheru, F (2001) The politics of poverty and debt in Africa's AIDS crisis, *International Relations*, XV(6), pp 37–55.

Robertson, R. (1996) *Globalisation: Social Theory and Global Culture* (Basingstoke: Macmillan).

Scholte, JA (1997) Global capitalism and the state, *International Affairs*, 73 (3).

World Bank (1994) *Development Report* (Oxford: Oxford University Press).

World Health Organisation (2000a) *Fact Sheet: Lassa Fever*, Fact Sheet No 179, April.

World Health Organisation (2000b) *Fact Sheet: Ebola Haemorrhagic Fever*, Fact Sheet No 103, December.

A human right to health?

TONY EVANS

ABSTRACT *A right to health is one of a range of socioeconomic rights for which states accept an obligation under international law. However, the politics of rights has meant that socioeconomic rights are rarely given the same status as liberal freedoms associated with civil and political rights. This article discusses the liberal rationale for rejecting socioeconomic claims as rights and examines the basic rights challenge to liberal arguments. Given the dominance of liberalism, the article concludes with an examination of the potential for promoting a right to health within the context of globalisation.*

There is a long and well established tradition of defending human rights in the pages of medical journals, dating from Thomas Wakley, who founded the *Lancet* in 1820 (Kandela, 1998). One of the most recent manifestations of this tradition was seen during 1999 when the *British Medical Journal* (BMJ) provided a forum for a debate between proponents and opponents of a human right to health. Opening the debate, the Tavistock Group offered a draft for a set of ethical principles which affirmed the human right to health. The draft sought to provide a basis for discussion among all branches of medical and health care professions that would finally end in general agreement on the nature of the right to health (Smith *et al.*, 1999). The fundamental principle underscoring the Tavistock Group's proposal was that, while the individual remained the claimant of a right to health, the delivery of the necessary services in response to that claim must be seen in the context of community. Accordingly, as a human right, the right to health cannot be bought and sold in the marketplace like other commodities. Nor can the right to health be limited by the ability to pay. Instead, according to the Tavistock Group, governments have an obligation to fund medical education, training and research, to make provision for sustainable investment in support of health care professionals, and to ensure that knowledge is exchanged freely and without regard for institutional affiliation and claims of ownership.

In response, arguments against a human right to health questioned the definition and extent of both human rights and health care. First, opponents of the Tavistock Group's proposal argued that, while civil and political claims are today generally accepted as human rights, 'it is difficult to find any rational or utilitarian basis for viewing health care in the same way' (Barlow, 1999: 321). Second, according to opponents, even if there were some general agreement on health as a human right, determining exactly who held a duty to provide the necessary resources in fulfilment of the claim remained problematic, even for the

provision of basic care. Third, opponents argued that any definition of health care would have to take account of a wide range of social, economic, organisational, scientific and technical issues and relationships before any general agreement on the extent of the right could be reached. Moreover, opponents noted that, even if this difficulty could be resolved, life and death decisions concerning availability and access would still need to be made as demand quickly outstripped supply (Loefter, 1999). It was therefore 'difficult to see how any provision of benefits [could] be termed a human right (as opposed to a legal entitlement) when to meet such a requirement would impose intolerable burdens on others' (Barlow, 1999: 321).

Although debates on health have often emphasised that good health can only be achieved within the context of social organisation, which pays particular attention to poverty, education, housing, economic globalisation and other social factors, this observation has often lacked any basis for justifying greater attention to health. According to some commentators, the human rights movement offers this justification by identifying the 'preconditions for human well-being', which then act as a 'framework for analysis and direct responses to societal determinants of health that is more useful than traditional approaches' (Mann, 1997: 23). This approach seeks to bring together the public health and human rights movements as a single, mutually supportive project said to strengthen at least some claims for social rights. Its success in part might be seen in the Harvard School of Public Health's practice of presenting all graduates with a copy of the Universal Declaration of Human Rights along with their diploma (Mann, 1996). However, the responses to the Tavistock Group's proposal noted above, which are well known within the human rights literature, reflect a liberal understanding of human rights that continues to dominate most 'human rights talk' in both academic and policy circles (Vincent, 1986). Given the dominance of the liberal consensus, the prospects for promoting the cause of health as a human right may therefore be less promising than many would hope. It is the task of this article to examine the potential for linking human rights and health in the current global world order.

Before beginning this task, we should be clearer about what we mean by a right to health. If we take the World Health Organisation's (WHO) definition of health as 'a state of complete physical, mental and social well-being' at face value, and attempt to promote this definition as the basis for a right to health, we might end with absurd claims to outlaw disease, the infirmities brought by aging and even mortality. While the social attitudes to health in many wealthy countries suggest that the idea of infinite mortality is desirable and attainable, proponents of a right to health are more concerned with social, economic and political arrangements that sustain the conditions for health security. Among other things, these include access to health care and the availability of drugs, but also the provision of sewage disposal, housing, education, environmental security and workplace health and safety measures. The right to health is therefore better thought of as '[w]hat we as a society do collectively to ensure the conditions in which people can be healthy' (International Federations of Red Cross and Red Crescent Societies and Francois-Xavier Bagnoud Centre for Health and Human Rights, 1999: 29). Put more formally, and emphasising the non-scientific

dimensions, health is concerned with 'the art and the science of preventing disease, promoting health, and extending life through the organised effort of society' (Acheson, 1998). Arguments to do with a right to health are therefore concerned with claims to live in a physical and social environment that does not prejudice the prospects for leading a full and healthy life, including access to health services.

This article will begin with a brief examination of the liberal consensus on universal human rights. This consensus accepts civil and political claims as human rights but relegates socioeconomic claims, including the right to health, to the status of aspirations. Furthermore, the liberal consensus supports this approach by asserting that rights are meaningful only when a duty to fulfil a claim is clearly established, which cannot be achieved in the case of socio-economic rights. At the centre of this assertion is the argument that, while people clearly need food, shelter and an environment that sustain good health, there is no reason to believe that these needs create an obligation on the part of others to provide them (Bole, 1991). A further defence for rejecting socioeconomic claims as human rights is the scarcity argument, which asserts that, even if it were possible to establish a clear duty on the part of the wealthy to provide basic needs to the poor, fulfilment of such a duty would be too burdensome on the rich. This fear is often expressed as the 'deluge' effect, an emotive term suggesting that the rich would drown in the sea of socioeconomic claims made by the poor. Moreover, liberals claim that, given the pace of technological and scientific change in the field of health, which can never be made available to all, the problem of the 'deluge' is exacerbated. The section finishes with a discussion of the social consequences that follow from the liberal consensus.

The second section offers a brief examination of the basic rights approach to human rights, which seeks to undermine the foundations of the liberal consensus by arguing that civil and political rights and freedoms cannot easily be distinguished from socioeconomic claims, as liberals assert. A third section returns to the health consequences of the liberal consensus in the light of basic rights arguments. In particular, this section will argue that establishing a duty to create the conditions for the fulfilment of socioeconomic rights is possible. However, the prevailing economic orthodoxy, which is seen in the policy formation and practice of the international financial institutions and the World Trade Organization (WTO), offers little hope for those who lack the conditions for good health.

The liberal consensus on universal human rights

One further observation should be made before looking at the liberal consensus on human rights. In contrast to the responses to the Tavistock Group's assertion that there is a right to health, Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) states that everyone has the right 'to the enjoyment of the highest attainable standard of physical and mental health'. Therefore, if the liberal rejection of socioeconomic rights has any legitimacy, it cannot be within the legal debate, but must instead be found in the philosophical or political debates that together with law form the three branches

of human rights talk. The practice of shifting seamlessly between the legal, philosophical and political debates on human rights is a common, if unfortunate, trait found within the literature (Evans, 2001b), and one that often distorts the claims made for human rights. For those who seek to reject the right to health, the propensity to shift among the three debates opens the space for liberals to reject socioeconomic rights, even in the face of the legal obligations most states now accept under international law. This is convenient for the dominant liberal consensus in global politics because it opens the possibility of gaining the moral status that ratifying international human rights law brings while simultaneously denying socioeconomic rights philosophically and politically.

Liberal arguments against accepting a right to health as a human right rest upon the presumption that civil and political rights are qualitatively and significantly different from socioeconomic rights. This distinction is usually expressed as that between 'negative' rights (civil and political) and 'positive' rights (economic and social). Although not expressed explicitly in these terms, disagreements over negative and positive rights are at the heart of the BMJ debate on health and human rights referred to earlier. Following this distinction, negative rights are fulfilled when all members of a community exercise restraint from doing anything that might violate the freedoms of others. Positive rights, on the other hand, require others to provide the material means of life to those unable to provide for themselves: at a minimum, clean water, shelter, food and health care (Plant, 1993). Put simply, the protection of negative rights demands nothing more than forbearance, while the protection of positive rights demands a redistribution of resources.

The defence of negative claims as the limits of universal human rights rests upon several assumptions. First, negative rights can be guaranteed through the simple expedient of passing national laws that guarantee negative freedoms. Negative rights are therefore cost-free in as far as they require restraint rather than a costly redistribution of resources. Second, since all rights are claimed against the state, and positive rights depend upon the level of economic development a country has achieved, setting any universal standards for economic and social rights is impossible. To attempt to do so would demand that some countries acknowledge rights that they could not realistically deliver, effectively asking them to brand themselves as human rights violators. Third, economic and social claims, like the right to a certain standard of living or health care, are culturally determined. To talk of a universal right to 'paid leave' during pregnancy and following childbirth (ICESCR, Art.10(2)), for example, makes no sense in societies where the concept of 'paid work' or 'leave' has no meaning. Fourth, the correlative duty of forbearance clearly rests with all members of society when negative rights are claimed but this is not so for positive rights. Indeed, the attempt to impose a duty on the wealthy to fulfil positive rights may conflict with negative freedoms, particularly those associated with economic activity, including free market practices and the freedom to own and dispose of property. Fifth, since the right to life is the most basic universal right from which all other claims derive, and the right to life is one of forbearance, negative rights must be ranked above positive rights. Lastly, liberals argue that positive claims cannot be understood as human rights because rights are claimed by the