

THE RIGHT TO HEALTH: WHAT CORPORATE DUTIES?

by Klaus M. Leisinger

1. Introduction

To improve the health situation of underprivileged women and girls in any place of the world is definitely a highly valuable objective. And it is even more valuable if it is done in a exemplary, innovative, and cost-effective way that might serve as a “proof of concept” model to be up-scaled elsewhere. Beyond the immediate and local benefits, such programs also contribute to an ever more important general endeavor – to respect, protect, fulfill, and promote the right to health.

While it is obvious that states are the primary duty-bearer in this regard, wide parts of modern societies expect business enterprises to also contribute toward the right to health in a measurable and significant way. This essay considers this issue and tries to come up with some answers to questions about corporate contributions toward the right to health. In this context, it is important to develop a consensus model of what a fair sharing of responsibility in a global society could be.

The “right to health,” being part of the economic, social, and cultural human rights catalogue, has gained substantial political importance as well as theoretical significance in conjunction with the rising popularity of the “rights-based” rhetoric permeating many political and social movements.¹ Rights-based development policy concepts place the respect, protection, and fulfillment of all human rights in the center of the development debate.² In the context of corporate responsibilities for the right to health, rights for which there is a *legal* obligation for a state may constitute a *moral* obligation for a non-state actor. Yet for many business enterprises this remains uncharted territory – dealing with a human rights obligation that includes affirmative steps to respect, protect, and fulfill those rights in their sphere of influence.

The “right to health” concept emphasizes the link between the health status of a person and issues such as dignity, justice, non-discrimination, gender, and participation. The consensus of international institutional thinking – since the World Health Organization (WHO) was formed in 1946 through to the International Covenant on Economic, Social and Cultural Rights in 1966, other human rights treaties, the Health for All by the Year 2000 objective of the Alma-Ata Conference on Primary Health Care in 1978, and the UN Millennium Declaration in September 2000 – is that every human being is entitled to the

1 Article 1 of the Declaration on the Right to Development, adopted by General Assembly resolution 41/128 of 4 December 1986, reads “The right to development is an inalienable human right by virtue of which every human person and all peoples are entitled to participate in, contribute to, and enjoy economic, social, cultural and political development, in which all human rights and fundamental freedoms can be fully realized.” Respective (vague) duties could be deduced from the wording of Article 3: “States have the primary responsibility for the creation of national and international conditions favorable to the realization of the right to development....The realization of the right to development requires full respect for the principles of international law concerning friendly relations and co-operation among States in accordance with the Charter of the United Nations.” And “States have the duty to co-operate with each other in ensuring development and eliminating obstacles to development. States should realize their rights and fulfill their duties in such a manner as to promote a new international economic order based on sovereign equality, interdependence, mutual interest and co-operation among all States, as well as to encourage the observance and realization of human rights.”

2 For an interesting way to deal with this issue, see UNHCHR: *Human Rights Approach to Poverty Reduction Strategies*, at www.unhchr.ch/development/povertyfinal.html; see also OHCHR: *Human Rights and Poverty Reduction. A Conceptual Framework*. New York / Geneva 2004.

highest attainable standard of health conducive to living a life in dignity.³ This consensus is also the background and justification of a Special Rapporteur of the UN Secretary General for the Right to Health, Paul Hunt.⁴

The academic “right to health” debate took off powerfully in 1994 in an article by Jonathan Mann.⁵ He discussed the positive and negative impacts of different health policies, programs, and practices on human rights (such as the fact that a state’s failure to recognize health problems that unduly affect a marginalized or stigmatized group violates the right to non-discrimination); the health effects of human rights violations (such as torture, imprisonment under inhumane conditions, or rape); and the fact that the promotion and protection of health are inextricably linked to the promotion and protection of human rights and dignity (as when dealing with HIV/AIDS).

The interrelatedness and interconnectedness of health and development were prominently acknowledged by the United Nations in the specific and measurable health targets contained in the Millennium Development Goals (MDGs). Although progress can be achieved if the political will is mobilized and if best practices are applied, most countries are still far from achieving these goals,⁶ particularly the health-related ones on child and maternal mortality and on sanitation.⁷

2. The Poverty Context: The State of Human Development in 2006

Despite the fact that the last 50 years were the most successful ever in the fight against poverty, the current state of development is characterized by an enormous amount of human misery, demonstrating the staggering challenges ahead:⁸

- 1 billion people are living on less than \$1 a day, 2.5 billion on less than \$2 a day.
- 850 million people – including one in three preschool-aged children – are undernourished.
- 1.8 billion people do not have access to improved water sources, and 2.9 billion people lack access to adequate sanitation.

3 Article 25.1 of the Universal Declaration of Human Rights (1948) affirms that “everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services.” The International Covenant on Economic, Social and Cultural Rights (1966) interprets this in article 12.1 as “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” A similar articulation, “the enjoyment of the highest attainable standard of health as a fundamental right of every human being,” was enshrined in WHO’s constitution over 50 years ago and is part of numerous international treaties and conventions (see WHO: *25 Questions & Answers on Health & Human Rights*, in WHO Health & Human Rights Publication Series, Issue No. 1, July 2002). Last but not least, the General Comment No. 14 (2000) on “Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights” reaffirms the “right to the highest attainable standard of health” (United Nations Economic and Social Council, E/C.12/2000/4, 11/08/2000).

4 See www.ohchr.org/english/issues/health/right/annual.htm as well as his latest analysis for the Human Rights Council: Implementation of General Assembly Resolution 60/251 of 15 March 2006, Report of the Special Rapporteur on the right of everyone of the highest attainable standard of physical and mental health, Paul Hunt, advance edited version, A/HRC/4/28, 17 January 2007, para 18–24.

5 Mann J.: Health and Human Rights. In: *Health and Human Rights: An International Journal*, Vol. 1 (1994), No. 1.

6 See UNDP: *Human Development Report 2003. Millennium Goals: A Compact Among Nations to End Poverty*. Oxford University Press, New York 2003, pp. 97ff; see also *Finance & Development*, Vol. 40 (2003), No. 4, pp. 12–41.

7 See Baird M. / Shetty S.: Getting There. How to Accelerate Progress Toward the Millennium Development Goals. In: *Finance & Development*, Vol. 40 (2003), No. 4, p. 16.

8 Estimated data, taken from World Bank’s World Development Indicators 2006, devdata.worldbank.org/wdi2006.

- 30,000 children under 5 years of age die every day, mainly from dehydration, undernourishment, and preventable diseases.
- Every year more than 500,000 women die in childbirth – one every minute of every day.
- 40 million people are living with HIV/AIDS, 25 million of whom are in sub-Saharan Africa. In 2005, some 3 million people died of AIDS and another 5 million became infected with HIV.

A regional breakdown shows that sub-Saharan Africa and South Asia remain the absolute poverty regions of the world.

No other indicators demonstrate the North-South gap in the physical quality of life as dramatically as health-related ones. There is a fundamental relationship between health deficits and poverty.⁹ Poor people who lack education on health matters and have limited or no access to adequate nutrition, safe water, and sanitation also are not likely to have the purchasing power to buy basic health services. Four broad mechanisms are responsible for and contribute to the perpetuation of health disparities:¹⁰

- *social stratification* – the very fact that people are poor in a poor social environment;
- *exposure* – a greater exposure to multiple health risks (malnourishment, unsafe water, lack of health knowledge, etc.);
- *susceptibility* – greater vulnerability due to the interactions among multiple health risks; and
- *precariousness* – potentially catastrophic income loss, loss of land or livestock, school dropouts, or illness-produced disadvantages that keep the vicious poverty-illness circle intact.

All these factors are almost totally out of reach of corporate responsibilities. The realization of the *right to health* – however defined – is connected to progress in the realization of all the civil and political as well as economic, social, and cultural human rights contained in the Universal Declaration of Human Rights (UDHR): “the right to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition of torture, privacy, access to information, and the freedoms of association, assembly and movement.”¹¹

Sustainable progress in the state of health requires more than just appropriate policies and allocations of resources to a ministry of health. It depends on and is instrumental in poverty alleviation. Poverty reduction strategies can only be successful if they are backed up by a number of synergistic measures and complementary approaches that respect, protect, and fulfill human rights, including but not limited to the right to health. A precondition for this to happen is more “voice” – that is, less discrimination against and more political impact for the poor as well as more participation in the affairs that affect their daily lives.

Many of the greatest disparities with fatal consequences are due to discrimination against women and girls.¹² Violations of basic human rights – such as the “right to say no” to sexual coercion, to unsafe sex, and to forced or child marriages; freedom from genital mutilation; and reproductive choices, to mention just a few – still result in 500,000 girls and women dying every year, virtually all of whom are in developing countries, from preventable conditions and injuries related to pregnancy and childbirth. More women than men, at younger ages, are living

9 See Leisinger K.M.: *Health Policy for Least Developed Countries*. Basel (Social Strategies, Vol. 16) 1985 (available through the Novartis Foundation for Sustainable Development, CH-4002 Basel).

10 See Carr D.: Improving the Health of the World’s Poorest People. In: Population Reference Bureau: *Health Bulletin*, Vol. 1 (2004), No. 1, p. 14.

11 Economic and Social Council, General Comment No. 14: The right to the highest attainable standard of health, 11.8.2000., para 3. The United Nations Committee on Economic, Social and Cultural Rights is a group of experts nominated by the countries that have ratified the International Covenant on Economic, Social and Cultural Rights.

12 See Germain A.: Reproductive Health and Human Rights. In: *The Lancet*, January 3, 2004, pp. 65f.

with HIV/AIDS – the majority of the people aged 15–24 who are infected with HIV-1 in sub-Saharan Africa are female. Girls and women continue to be discriminated against by a “cultural mindset” (which is sometimes defended by religious fundamentalists on a supposedly religious base) that results in no or severely impaired access to food, health care, education, and employment. A concerted effort to guarantee human rights in a gender-neutral way would not cost a great deal and would save millions of lives.

Contrary to the insinuations contained in widespread criticism about the pharmaceutical industry’s patent and price policy, it is rarely the patented high-tech solutions that are needed to combat typical poverty-related diseases. Poverty alleviation in general and especially targeted interventions – better nutrition education for mothers (including on the importance of breastfeeding), mass vaccination campaigns, access to basic antibiotics, bed nets for malaria prevention, and condom use programs to prevent the spread of HIV/AIDS and other sexually transmitted diseases – are highly effective in reducing preventable mortality. The combination of these with well-known and inexpensive basic health interventions would have a dramatically positive impact on the health of the poor.

3. Bearers of Duties

A meaningful discussion of rights must deal with the respective duty-bearers. As with all rights formulated in the UDHR, states are the primary bearers of duties. In the context of a “right to health,” however, it is important to mention that along with environmental, social, and economic factors, genetic factors, and the availability of health care, there are also lifestyle issues – and hence important duties for each individual on the personal level.

A. Individual Duties

While governments should play a stronger role in risk prevention policies, education, and social marketing, individuals must accept their part of responsibility for their own health. Individual commitment and corresponding actions cannot be replaced by communities or governments and even less by the international community. Duties in the context of the right to health begin at home and include healthy nutrition, risk-avoiding lifestyles, and refraining from alcohol, nicotine, and drug abuse.

B. Community Obligations

Local communities can do much to improve people’s perception of health risks and to reduce them. Functioning communities regard it as their essential obligation to analyze health-related problems, determine needs, initiate community efforts, and mobilize resources that will improve health-related infrastructure (such as supplies of safe water), that will eliminate habitats for vectors that spread diseases, that will provide support and care for the needy, and that will train community workers for health, education, and other items. Significant health results can be achieved without many financial resources; even poor communities can achieve a great deal, such as encouraging health-promoting behaviors (breastfeeding, use of mosquito nets, heating of unsafe water) and developing peer pressure against health risks (unsafe sex, excessive alcohol consumption, men’s violation of women’s reproductive rights).

C. Nation-State Obligations

All human rights are above all incumbent on States and their institutions. States thus do have the primary responsibility to respect, protect, and fulfill people’s right to health. According to the Committee on Economic, Social and Cultural Rights, this means the following:¹³

- *Obligations to respect* include, among other considerations, refraining from denying or limiting equal access for all persons to preventive, curative, and palliative health services

¹³ See Economic and Social Council, General Comment No. 14: The right to the highest attainable standard of health, 11.8.2000.

but also refraining from prohibiting or impeding traditional preventive care, healing practices, and medicines. (§ 34)

- *Obligations to protect* include, among other considerations, the duty to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability, and quality of health facilities, goods, and services. (§ 35)
- *Obligations to fulfill* require states to, among other things, adopt a national health policy with a detailed plan for realizing the right to health; to ensure provision of health care, including immunization programs against major infectious diseases; to ensure equal access to all the underlying determinants of health (safe food, potable water, basic sanitation, and so on); and to ensure the provision of a sufficient number of hospitals, clinics, and other health-related facilities as well as a public, private, or mixed health insurance system that all can afford. (§ 36)

States and their institutions must do away with torture, violence against children, and harmful traditional practices that violate human rights and the health of the victims.¹⁴ Once the non-negotiable essentials have been achieved, the continuous battle for the fulfillment of the right to health must be fought on at least three fronts:¹⁵

- Use non-health interventions to provide health benefits, such as by providing clean water, improving sanitation, offering better primary education, and improving governance and basic infrastructure.
- Deliver medical interventions, such as vaccines and drugs, medical examinations, tests, and cost-effective treatment – especially to poor people (most benefits from public spending on curative health services go not to the poorest but to the better-off).¹⁶
- Deliver non-medical health interventions, such as training medical personnel, building better health information systems, and strengthening systems for procuring and storing.

Health policy impact depends on the efficacy of the public sector and the incentive structures of the given institutional arrangements. Wherever the capacity and efficacy of the public sector is low – and it has been low in many instances – adopting strategies that put a greater workload on public institutions may be the wrong choice.¹⁷ There is mounting evidence that non-governmental organizations (NGOs) and the private sector can in some cases deliver essential and other services to poor people more efficiently than the public sector can.¹⁸

While poor countries, by definition, do have an overall resource scarcity problem, the *allocation pattern of available resources* remains an ongoing issue. Statistics from the UN Development Programme and the World Bank are readily available to prove that a number of governments in the developing world spend up to five times as much on the military as on health. Violations of the state's obligation to fulfill people's right to health include the failure to adopt or implement a national health policy designed to ensure the right to health for everyone, as well as insufficient expenditure or misallocation of public resources to guarantee minimum levels of primary health care, including essential drugs, which results in non-enjoyment of the right to health by individuals or groups, particularly the vulnerable or

14 See WHO, *25 Questions & Answers on Health & Human Rights*, Health and Human Rights Series, Issue No. 1, July 2002, p. 10.

15 See Bloom D.E. / Canning D.: A New Health Opportunity. In: *Development*, Vol. 44 (2001), No. 1, pp. 36ff.

16 See, e.g., Castro-Leal F. et al.: Public Spending on Health Care in Africa: Do the Poor Benefit? In: *Bulletin of the World Health Organization*, Vol. 78 (2000), No. 1, p. 70.

17 See Filmer D. / Hammer J. / Pritchett L.: *Health Policy in Poor Countries: Weak Links in the Chain*, 11/1999, World Bank Policy Research Working Paper No. 1874.

18 See Hecht R. / Batson A. / Brenzel L.: Making Health Care Accountable. Why Performance-based Funding of Health Services in Developing Countries is Getting More Attention. In: *Finance & Development*, Vol. 41 (2004), No. 1, pp. 16–19. See also World Bank: *World Development Report 2004. Making Services Work for Poor People*. Oxford University Press, New York 2003.

marginalized. While the International Covenant on Economic, Social and Cultural Rights endeavors to guarantee minimum levels of subsistence to people in poor nations,¹⁹ the principle of “free public health care” remains a subject of discussion.

A last important point: The interpretation of economic and social rights cannot be made irrespective of the stage of development of a country, its available capabilities and resources, and the competing claims on these resources. Social services in the quantity and quality provided in a mature European nation are and will remain for the foreseeable future well out of reach for any sub-Saharan African or South Asian nation.

D. Obligations of the International Community of States

For the sake of a fair discussion of the right to health in a corporate context, it is important to emphasize that where the primary duty of the state is neglected – whether from a lack of resources or deficits in governance – first and foremost the international community ought to be called to account. With development assistance in the case of incapability and with a mixture of pressure and incentives in the case of unwillingness, the international community is expected to take joint action to achieve full realization of the right to health. Richer nations in particular are called on to facilitate access to essential health facilities, goods, and services in poor countries wherever possible and to provide the necessary aid when required.²⁰

Drawing attention to the legitimate sequence of legal duties for the respect, protection, and fulfillment of the right to health is necessary for at least two reasons:

- to avoid pushing the debate to the wrong side, thus letting primary duty-bearers get away with non-performance and putting the blame for mass sickness on other actors; and
- to avoid the development of unrealistic expectations about sustainable deliverables from the private sector, especially pharmaceutical corporations.

Many individuals and major business associations are concerned that where states are incapable or unwilling to fulfill their duties, their human rights obligations are pushed onto non-state actors, especially multinational business enterprises.

In accordance with Articles 55 and 56 of the UN Charter, international cooperation for development and the realization of human rights is an obligation of all states. International political consensus sees first and foremost bilateral and multilateral development assistance and specialized UN agencies, in particular WHO, as having a role in realizing of the right to health at the international, regional, and country levels.

A number of binding treaties strive for a new international economic order based on sovereign equality, interdependence, mutual interest, and cooperation among all states. From time to time these have been reinforced, as in the Millennium Declaration, when 147 Heads of State and Government recognized “that, in addition to our separate responsibilities to our individual societies, we have a collective responsibility to uphold the principles of human dignity, equality and equity at the global level.”²¹

The practical consequences of the commitments made have been less than impressive, however. Although in the past few years official development assistance (ODA) has increased, to 0.33 percent of gross national income in 2005, it still falls short of the 0.54 percent that the Millennium Project estimates will be necessary to achieve the MDGs. With regard to health issues – which three of the eight MDGs relate to – the positive news is that the portion of ODA going to these issues has increased considerably during the last few years, to 15 percent in 2004.

19 See Economic and Social Council, General Comment No. 14: The right to the highest attainable standard of health, 11.8.2000., para 52.

20 Ibid., para 39.

21 Resolution adopted by the General Assembly 55/2: United Nations Millennium Declaration.

Yet compounding the fact that the overall aid level is still too low to meet the basic health needs of poor countries, there are acute problems with achieving reasonable aid effectiveness.²² We seem to be far removed from averting 8 million deaths annually, which would yield economic benefits on the order of \$360 billion, by properly investing additional \$31 billion a year in donor assistance for health, as the Commission on Macroeconomics and Health estimated.²³ Newer studies suggest an even higher impact of health improvements on the economies of poor countries.²⁴ A key for this might be the adoption of a rights-based approach by crucial institutions like WHO as well as by influential governments like the United States, which continue to resist economic, social, and cultural rights, including the human right to the highest attainable standard of health.²⁵

E. Non-state Actors' Obligations

The discussion about non-state actors is restricted here to the two groups most present in the public debate about health issues: NGOs and the private sector.

Consultations with poor people reveal that they consider governments to be very important but their actions rather ineffective and sometimes harmful.²⁶ Problems of corruption emerge in many cases as a key issue in people's daily struggles – whether it is to get an education for their children, access to justice or police protection, or access to basic health care. NGOs, in contrast – in particular, emergency aid NGOs and religious organizations – rate well in responsiveness and trust. They have a role in facilitating the voices of poor people and they can be helpful in supporting the formulation and implementation of policies that actually benefit the poor. NGOs such as Oxfam were among the first to make human rights an integral dimension of the design, implementation, monitoring, and evaluation of health-related programs. While NGOs should not be considered the “silver bullet” for solving all grassroots health problems, they are an important link in the chain.

For the private sector, meaningful answers and sustainable corporate commitments require not only differentiating political and civil human rights from economic, social, and cultural human rights but also defining the boundaries of corporate obligations in a fair societal distribution of responsibility.²⁷

The prime responsibility of corporations is to respect, protect, and contribute toward fulfillment of human rights in the context of normal business activities and to strive to ensure that a company's activities do not contribute directly or indirectly to the violation of the obligation to respect, protect, and fulfill the right to health. Successful pharmaceutical companies contribute in particular through the results of their research and development

22 See Schieber, G. / Fleisher, L. / Gottret, P.: Getting Real on Health Financing, In: *Finance & Development* Vol. 43 (2006), No. 4.

23 Commission on Macroeconomics and Health: *Macroeconomics and Health: Investing in Health for Economic Development*. WHO, Geneva 2002, Foreword.

24 See Bloom D.E. / Canning D. / Jamison D.T.: Health, Wealth, and Welfare. In: *Finance & Development* Vol. 41 (2004), No. 1, pp. 10–15.

25 See Human Rights Council: Implementation of General Assembly Resolution 60/251 of 15 March 2006, Report of the Special Rapporteur on the right of everyone of the highest attainable standard of physical and mental health, Paul Hunt, advance edited version, A/HRC/4/28, 17 January 2007, para 49–50.

26 See Narayan D. et al.: *Voices of the Poor. Can Anyone Hear Us?* Oxford University Press/World Bank, Washington DC 2000.

27 See Leisinger K.M.: On Corporate Responsibility for Human Rights (Report of the Special Advisor of the Secretary General on the Global Compact, at www.unglobalcompact.org/NewsAndEvents/articles_and_papers/index.html); see also Leisinger, K.M. Business and Human Rights. In: McIntosh M. / Waddock S. / Kell G. (eds.): *Learning to Talk: Corporate Citizenship and the Development of the UN Global Compact*, Greenleaf Publications, London July 2004. While international human rights law considers it important to address *all* human rights on an equal footing and holistically, I consider from a corporate point of view the economic, social, and cultural rights to be the real challenge and hence make this separation.

endeavors being used to cure diseases, prevent premature mortality, and shorten hospital stays. As I am most familiar with the pharmaceutical industry, examples here are drawn from this sector.

Sincere corporate commitments in the context of the right to health must be handled with care:

- On the one hand, there is a structural problem, as private enterprises – being market-oriented and profit-driven – run up against limits in cases of market failure; things turn even worse if market failure and state failure come together and create negative synergies for the poor.
- On the other hand, to shrug the “corporate shoulder” and walk away doing nothing in the face of the biggest social problem of humankind is not an acceptable option. The situation presents a challenge and an opportunity for moral leadership and corporate vision to determine how much should be done, in what areas, for whom, in partnership with what stakeholders, over what period of time, and so on.

A sustainable corporate responsibility approach will carefully examine and decide on the nature and dimension of corporate obligations. It will also define the boundaries beyond which further corporate contributions are seen as unreasonable by management. As with other corporate social responsibility aspects, corporate obligations to respect, protect, and fulfill the right to health encompass responsibilities with differing degrees of obligation. A suitable distinction can be drawn among:²⁸

- *essential* responsibilities required of any corporation for the respect of the right to health (the “*must*” dimension);
- additional corporate responsibility standards beyond what usually is enshrined in national law, meaning what can reasonably be *expected* by society (the “*ought to*” dimension); and
- special corporate responsibility endeavors such as corporate philanthropy (the “*can*” dimension).

The “Must” Dimension

With regard to respect for the right to health, as with all other human rights a company competing with integrity complies in its own sphere of influence with all laws and regulations concerning healthy workplaces, environmental protection, and the safety of products and services.

A pharmaceutical corporation is particularly able to make further substantial contributions through its cutting-edge research, development, and manufacture of high-quality drugs. This helps reduce premature mortality as well as prevents or cures diseases that are susceptible to drug therapy, which in turn raises the quality of life of sick people, avoids costly hospitalization, and allows people to go back to normal working lives instead of being bedridden.

Under constructive political and social conditions (“good governance”), these corporate contributions are of major instrumental value in enabling individuals to lead a healthy life as well as the state to bear its right-to-health duties. In addition, through the wages paid to staff, employees are empowered to fulfill their economic, social, and cultural rights. And through taxes paid, the state is enabled to fulfill its duties.

The “Ought to” Dimension

Responsible companies will deliver more than just the essentials. This is particularly so in countries where the legal standards are low or not enforced. Such companies – due to having

28 This follows Dahrendorf’s distinction of norms that – together with expectations and sanctions of others – determine the “homo sociologicus”; see Ralf Dahrendorf: *Homo Sociologicus*, 16. Aufl., Wiesbaden 2006.

appropriate corporate responsibility guidelines in place – will adhere to their self-imposed corporate responsibility norms even if local laws and regulations allow lower standards. They will do their best to avoid benefiting from unhealthy working conditions or unsafe workplaces of third parties within their sphere of influence.

For employees in the developing world, it can be regarded as best practice particularly for a pharmaceutical company to establish a comprehensive program of medical services that includes free or heavily subsidized facilities for diagnosis, treatment, and psychosocial care of workers with HIV/AIDS or other poverty-related diseases such as TB or malaria. Other relevant actions are, for instance, free or heavily subsidized meals, nursery schools for single mothers, free training opportunities using company infrastructure, and scholarship programs for the children of low-income employees.

The best pharmaceutical companies are willing to adapt, on the basis of a proper case-by-case evaluation, the prices of life-saving medicines for patients living in individual or collective poverty (at Novartis, examples of this include cooperation with WHO on malaria, which makes Coartem available at production cost, and the Gleevec patients' assistance program). And in an effort to protect participants of clinical trials all over the world, companies are well advised to adhere to the ethical principles of the Declaration of Helsinki on clinical trials.

The “Can” Dimension

Deliverables in the context of the “can” dimension consist of actions that are neither required by law nor well-established industry practice. These can involve corporate philanthropy, including donations of first-class quality medicine.²⁹ Other examples of engagements in this category are institutions engaging in not-for-profit research on neglected diseases (such as the Novartis Institute for Tropical Diseases, which is focusing on TB and dengue fever). Corporate philanthropy endeavors (expenditures beyond a company's actual business activities without any specific association with direct corporate advantages and without any financially measurable rewards in return) can have a significant impact on the well-being of poor people – and hence on fulfillment of their right to health.

For many reasons it can make sense to create an independent foundation to take care of challenges on the “can” dimension. At Novartis, the Foundation for Sustainable Development has made significant contributions by investing in projects and programs of development cooperation and humanitarian assistance and has helped to increase the effectiveness, efficiency, and significance of project-related aid. Contributions to the fulfillment of the right to health of people whose purchasing power does not allow them to benefit from health services provided through market mechanisms should help to establish best practices – defined as being innovative, making a positive difference, and having a sustainable effect as well as the potential to be replicated and to serve as a model for initiatives elsewhere.³⁰ Last but not least, donations in cases of acute emergencies (such as the tsunami) can play a significant role.

4. Conclusion: The Fulfillment of the Right to Health as a Multistakeholder Task

Given the huge extent and complexity of global health problems in the twenty-first century and considering the tragic human misery associated with premature death and preventable diseases, the right to health debate is expected to gain in importance. If “medical care” is considered a right, national governments and international institutions are the primary parties with the duty to make all reasonable efforts to respect, protect, and fulfill this right. Wherever responsible *national governments* start to meet this commitment by making informed decisions, based on the resources available,

²⁹ See www.novartisfoundation.com/pdf/Improving_Access_to_Leprosy_Treatment.pdf

³⁰ See Interim Report of the Special Rapporteur of the Commission on Human Rights on the Right of Everyone to Enjoy the Highest Attainable Standard of Physical and Mental Health, Paul Hunt (A/58/427), United Nations, New York 2003, p. 13.

- *excess mortality and morbidity will be reduced*, for example by focusing on interventions that can achieve the greatest health gains possible within prevailing resource limits – the vast majority of preventable diseases are the result of a relatively small number of identifiable deficits, and hence a focus on communicable diseases, health awareness programs, and immunization programs can dramatically improve health and reduce premature mortality;
- *potential threats to health will be countered*, for example by social marketing, with the goal of changing unhealthy environments and reducing risky behavior (such as environmental measures against vector-borne diseases like malaria as well as promotion of bed nets, the use of condoms, and the fight against tobacco addiction, but also health education for the prevention of cancer and cardiovascular diseases);
- *more effective health systems will be developed*, for example by setting priorities according to actual needs and giving incentives to improve health sector performance (given that the known and cost-effective interventions against the diseases that cause 50 percent of preventable deaths among the poor have been given insufficient priority within existing health systems);³¹ and
- *expanding the knowledge base will be assured*, simply by investing into this field consistently and coherently.

Second in the line of duty is the *international community*. A reality check shows that many poor countries with high infant and child mortality are not on track with regard to the achievement of the MDGs in general and – even more – with regard to health. Having completed already two thirds of the 1990–2015 period specified in the MDGs, the general child and maternal mortality goals are projected to remain unmet almost universally, with sub-Saharan Africa lagging behind most significantly.³² While part of this can be attributed to lack of good governance, industrial countries have failed to keep the promises they made and are still making. Each dollar going to development assistance still has to fight hard against hundreds of dollars spent for military and protectionist purposes.

And the *private sector*? Is there a right to health that poor people can call on to be sustainably *respected* by companies, particularly pharmaceutical companies? Yes, corporations all over the world and from all sectors have respective social and ecological legal duties within their normal business activities. Is there a right to health that poor people can call on to be sustainably *protected*? Yes, enlightened corporations strive to make sure that questionable labor standards and environmental practices are avoided in their sphere of influence. Is there a right to health that poor people can call on to be sustainably *fulfilled*? Yes, for those who are employed by the company, through a fair remuneration and by the employers' tax and insurance contributions. But beyond that?

The answer to this key question depends on whom you ask. There is a widespread moral recognition of deliverables beyond the supply of markets, the respect of law and proper norms, and the provision of productive employment. Today many companies, but by far not a majority of companies, do accept such responsibilities through the “can dimension” of corporate responsibility commitments. On its own, however, this cannot make more than a very limited contribution to overcoming the challenges we all face on a global level.

The huge mortality and morbidity burden can only be brought down with a *concerted strategy* that is supported globally with financial resources as well as know-how on good practices and with national and community efforts to increase the access of the world's poor to essential health services. It is obvious that single actors on their own will face narrow limits with regard to their impact on global development and health problems. Solutions of multifaceted problems of global dimensions must be approached with a multistakeholder

31 See Spinaci S. / Heymann D.: Communicable Disease and Disability of the Poor. In: *Development*, Vol. 44 (2001), No. 1, pp. 66ff.

32 United Nations, *The Millennium Development Goals Report 2005*.

approach. This is why all actors of society – state and non-state – are called on to contribute to solutions according to their obligations, abilities, and enlightened self-interest. The watershed for the credibility for all societal actors will be their willingness to make resources available and to cooperate in a creative way in order to meet all the Millennium Development Goals – and to fulfill the right to health.