

The Failure of Human Rights in Healthcare: Why a human rights framework leads to inefficient distribution of healthcare in the era of HIV

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The human rights doctrine has emerged as the hegemonic force for addressing social inequities in the 21st century. By assigning inalienable, absolute rights of the individual, human rights initiatives generate legal and moral structures that can guarantee the rights of the individual and offer recourse when those rights are infringed. In creating and protecting the rights of the individual, the human rights framework hopes to engender greater social utility. Human rights advocates hold this fundamental precept dear to their struggle for the greater adoption of human rights – that the protection of the individual betters the collective. In relation to health, however, this precept fails. The individual right to health does not necessarily benefit the collective because of the negative externalities produced by individual health-seeking behavior. Human rights advocates, though well-intentioned, need to adopt a different theoretical model when approaching individual and collective health.

While the human rights framework should not be the overarching model for healthcare provision, it has been successful in increasing the health status of individuals and collectives. A human rights approach to healthcare entails codifying legal entitlements to treatment and care and provides recourse if those rights are infringed. A human right to healthcare ensures that minority individuals or those without insurance will be treated because of the threat of legal action against those who refuse them treatment.¹ This right to treatment has resulted in free

¹ For the purposes of this paper, a human rights framework generally refers to an idealized legal system with strict human rights protections. This system would likely involve constitutional protections for a human right to health and a human right to healthcare; if these rights were infringed, an individual could sue the government to provide these rights. This governing structure does not currently exist in any nation, though nascent structures based on this model

medication for those who cannot afford it, life-saving surgeries for those in immediate danger, and preventative care for children not-yet-conscious of their need. The human right to healthcare has saved countless lives and improved even more, and to argue that it has been without positive effect unfairly belittles its contributions.

These contributions, though, do little to balance the need for collective health with individual health – the human rights framework has excelled at meeting the health needs of individuals, but it has failed to consider the ramifications on collective health and the net benefit of a human rights structure. Advocates correctly argue that increasing the life and health of one individual has a social benefit – that individual can work more, take care of her children, purchase goods, and contribute to society. Advocates do not consider, though, whether this social benefit is a **net** social benefit. Certainly, the human rights framework benefits the individual; that is its goal and its charge, and it performs admirably. In aggregate, however, the benefits to the individual do not necessarily result in an overall social benefit because the externalities of that individual change in health are not accounted for. A human rights framework legally empowers the individual with a right to healthcare, and this empowerment focuses health services on individual health rather than collective health.

In the era of HIV, the human rights focus on individual health discounts the health of the social collective because individual treatments for HIV can be detrimental to the whole. In Africa, the individual right to health has trumped the health of the collective in the fight against HIV. Because of their human rights doctrine, advocates in Africa have implemented legal

have been developed in South Africa and India. Because this paper argues that this ideal, wholly inclusive system of human rights fails in the adequate provision of health and does not promote the public health, it will use this theoretical and idealized system as the base for argument with several anecdotes of the current human rights implementation schema.

systems guaranteeing a human right to health and a human right to life.² These human rights systems obligate governments to provide healthcare services to all who need them and fault the government for not taking actions that may extend an individual life. In relation to HIV, these rights entail universal access to anti-retroviral (ARV) medications to fight HIV. Even in systems where the government is not mandated to provide such treatment, the human rights philosophy of many NGOs requires that they provide ARV treatment that extends individual lives.

This rights-based approach, however, undermines the health of the collective because of the limited efficacy of ARV treatment and the creation of drug-resistant strains of HIV. ARV treatment is a strict regimen of drugs that must be taken at specific time intervals. These treatments also must be taken with substantial food and require that the individual have strong nutritional support. Even when taken under these conditions, these drugs cause distressing side-effects, including redistribution of bodily fat, changes in bowel movements, and an overall feeling of malaise.³ Because of these side effects, ARV treatment regimens are often neglected by patients under the best of circumstances. Many ARV patients follow their ARV regimen until they no longer feel ill from AIDS, stopping when the burden of the side-effects outweighs the burden of the disease. However, neglecting treatment regimens causes drug-resistant strains of HIV to develop, limiting the efficacy of ARV treatment in individuals infected with the drug-resistant strains.

While these maleffects of HIV treatment are limited to the individual being treated, the drug-resistant strains of HIV that they produce are dangerous to the health of the social collective.

² (Singh, Govender and Mills 2007)

South Africa is the only African country to have a strong legally-codified human rights approach to healthcare. Unlike India, which includes allusions to human rights to health in its constitution, South Africa has defined the human right to health through the judicial system. Nevertheless, most scholars agree that this approach has led to a legally codified right to health and healthcare in South Africa which the government must provide under the law.

³ (International HIV/AIDS Alliance 2007)

Their danger is heightened because ARV treatment often encourages more sexual activity among those treated. Because ARV treatment reduced the symptoms of AIDS so drastically, individuals on ARV regimens often believe that they are no longer infected with HIV or that their HIV is not communicable. These individuals may engage in unsafe sexual practices that infect others with HIV. Worse, if these individuals have not appropriately followed their ARV regimen and have fostered the development of drug-resistant HIV, they may infect another person with a form of HIV impervious to ARV treatment. Even if an individual correctly follows his ARV treatment, he may still infect others through unsafe sex if he believes that the treatment reduces his infectiousness. Most damning, however, is the limited efficacy of ARV treatment – the ARV treatment available in Africa extends the life of most AIDS patients by only three to five years.⁴ Because of the individual right to healthcare, HIV-positive individuals are given ARV treatment, potentially creating drug-resistant strains of HIV and affording HIV-positive individuals more opportunities to infect others with the virus. Depressingly, these maleffects of treatment are offset by only two additional years of life for the individual.

Human advocates critique this argument by calling it a problem of implementation, but this critique does little to change the unfortunate reality on the ground. If we had food security, they argue, people would adhere to their difficult ARV treatment and impede the formation of

⁴ (Easterly 2006)

(World Health Organization 2005)

(World Health Organization 2009)

(Wood, Schechter, et al. 2000)

(Wood, Braitstein, et al. 2000)

The debate over the efficacy of ARV treatment is ongoing, and estimates have varied widely over the years. Easterly's estimates are based on a white paper from the Harvard School of Public Health. Other sources, including the World Health Organization (2005), have used figures as low as 3.1 years. In a forthcoming 2009 report (some information is available online), the WHO uses a figure of 19.3 years as a median survival time on ARV treatment and 10.9 years as the median. This, however, implies that half of those on ARV treatment live less than 10 years. Other reports (Wood, Schechter et al, 2000) use a figure of 5 to 7 years, though they indicate that the figure may be as low as 2 years. Wood, Braitstein et al. (2000) suggest 3 years. The variance in the figures is highly linked to regional implementation, different medications, and the difficulty in conducting long-term studies in resource-poor environments that track mortality.

drug-resistant strains. If we had better education, they argue, recipients would understand their ability to infect others and would only engage in safe-sex behaviors. If we had access to better ARV drugs, they argue, lives would be extended by ten or fifteen years, not one or two. If these conditions were met, they argue, a human rights framework would effectively remedy our HIV crisis. These hypotheticals, however, have not been met, and the over-valued individual right to healthcare continues to sap the collective of its right to health.

When human rights are codified into a legal code or institutional frameworks, they mandate the over-valuation of individual rights, harming the social collective. Human rights advocates astutely claim that there is a scenario where their approach will work, but they refuse to accept the danger of implementing a human rights framework outside of that scenario. Without meeting the conditions of food security, education, and better drugs, a human rights framework mandates that we **must** provide ARV treatment to the individual because of his absolute, inalienable right to healthcare. This right is so unalienable that when enshrined in legal code, it would punish those who withhold medical care to the individual even when withholding care benefits the collective. The absolute nature of human rights removes all discretionary power from implementers and healthcare practitioners – exactly as the human rights doctrine intends.

Under this disjunct, a human rights approach to healthcare is inefficient because the implementation fails to match the theory – a classic example of market failure under the theory of the second best. In economics, the theory of the second best offers a mechanism to explain program failure even in the presence of a sound theoretical framework.⁵ Assume a classical economic model where competition drives market efficiency – allowing each competitor to freely determine his own choices will tend towards social efficiency under the guidance of

⁵ (Lipsey and Lancaster 1956)

economic natural selection, the push of the invisible hand. In practice, however, markets have constraints on information flow and other inefficiencies that inhibit the efficient solution predicted by the model. To compensate for these inefficiencies, markets are regulated and the system is intentionally shifted from the theoretical, unregulated framework. The theory of the second best posits that in the presence of inefficiencies, shifting program implementation closer to the theoretical model is not necessarily more efficient if the original inefficiencies have not been solved. Indeed, the original inefficiencies may be intensified or compounded by a move towards the theoretical model, exacerbating existing problems. In our competitive market example, the theory of the second best implies that market regulation may be preferable to an unregulated market, even if it better resembles the theoretical model, because the underlying inefficiencies are still present. Under this framework, each additional step towards the theoretical model is not guaranteed to improve efficiency relative to the step before it if the underlying inefficient conditions have not been resolved.

Regarding the implementation of a human right to healthcare, the theory of the second best holds that implementing an individual, absolute right to healthcare fails in the presence of underlying inefficiencies. Because the negative externalities of individual actions cannot be addressed under this framework, employing a human rights doctrine may be more inefficient in providing appropriate levels of healthcare because it operates under an inefficiency-free framework in an inefficiency-riddled world. Economically, a human rights approach to healthcare results in poor outcomes because it forgoes real-world constraints and implements a theoretical model discordant with those constraints. Because of the absolute nature of human rights, this shoddy implementation particularly damns those countries where it has been legally

codified, as flexibly implementing an absolute right becomes legally perilous even when the outcome ultimately benefits the collective.

When healthcare rights are assigned to individuals, health provision is inefficient because the discrepancy between individual rights and collective rights cannot be negotiated. The human-rights approach to healthcare mimics the property rights of the Coase theorem, an economic model where clearly assigning property rights allows individual parties to negotiate for an efficient solution.⁶ In an apartment complex, for example, property rights could be assigned to either freedom to make noise or freedom from noise. If the right to make noise is implemented, then all parties who want silence would negotiate with the noise-making parties and pay them to be quiet. If the right to silence is implemented, those who care for loud music would negotiate with the other tenants and pay them for the right to be loud. In each situation, clearly assigned property rights facilitate the negotiating process. Under real circumstances, however, property rights are rarely negotiated, even when clearly defined, because of the barriers to negotiation – budget constraints that limit the ability to pay noisy neighbors and social desirability concerns that inhibit bargaining. Because of these inefficiencies, property rights are assigned only in the dormitories of economists. Under the Coasian framework, inefficiencies in an individual right to health could be negotiated away by the collective; in practice, however, the collective has no power to pay the individual not to be treated for HIV or to take his ARVs regularly enough to inhibit the formation of drug-resistant HIV. The rights framework fails because the best solution, a mix of individual and collective rights to health too complicated to be legally codified, cannot be negotiated under a framework of absolute rights. Here, the theory of the second-best holds

⁶ (Coase 1960)

that assigning rights and allowing for negotiations is inefficient in practice because of the real-world constraints on the theoretical model.

Because Coasian property rights fail in the implementation of a human right to healthcare, human rights advocates must question whether the theoretical construct is worth the poor results. Assigning an individual human right to healthcare does not result in an efficient distribution of healthcare for the collective because of underlying inefficiencies. While these inefficiencies may be accredited to problems of implementation, the theory of the second best demonstrates that these implementation concerns are valid reasons to abandon the pursuit of a theoretical model. Implementation concerns can never be entirely eliminated; for human rights advocates, it is time to question whether a human rights approach to healthcare will positively benefit the collective outside of theoretical modeling. In this era of HIV, will the model hold in the face of drug-resistant HIV, incorrect assessments of HIV infectiousness, and HIV treatments of limited efficacy? Advocates must question whether the moral benefits of a human rights approach are enough to justify the inefficient delivery of healthcare that they engender.

Human-rights inefficiencies are particularly dangerous because of the hegemony of the human rights doctrine, a doctrine that explicitly values the individual over the collective. In a micro-hegemonic sense, the human rights doctrine controls all distribution of healthcare relative to its definition of rights. When an organization or a nation becomes bound by the human rights approach, those individual rights cannot be violated for the benefit of the collective because of their inalienable, absolute nature. Human rights do not allow for triage; in a human rights system, no right can be more valuable or pressing than another because all rights are absolute. In a healthcare context, this hegemony of absolute rights ties the hands of real-world practitioners

from plying their trade as efficiently as possible to benefit the individual or the collective relative to the situation.

In addition to micro-hegemonic control of the physical distribution of healthcare, employing a human rights doctrine becomes an inefficient macro-hegemonic force that negates the power of other, more efficient approaches to implementing systems of healthcare distribution. When a human rights framework guides the structure of a nation or an organization, it precludes the use of other empowerment and health care distribution strategies that may be more efficient. The human rights framework prevents the introduction of a socialist approach to healthcare because the individual right to healthcare can be negated in favor of a more pressing social need. A human right to healthcare supersedes a religious or moral obligation to provide healthcare that is separate from the recipient's right to care – under a human rights framework, a doctor provides care because the patient has a right to care, not because the doctor offers care from a religious or moral motivation. That motivation may still be present within the doctor herself, but the organizational human rights structure that guides her work does not utilize the religious or moral belief to provide care as a motivating strategy. Once the human rights doctrine is in place, it exerts a macro-hegemonic force that negates the power of other healthcare strategies with little regard to which strategy may be most efficient.

The hegemony of a human rights approach to healthcare results in inefficient provision of care because it cannot be flexible in its implementation, devalues the health of the collective, and limits the implementation of alternative, non- rights-based approaches to healthcare distribution. The use of a human rights framework is particularly troubling in the era of HIV, as the costs of this inefficient system are significantly higher. Though it maintains an untouchable moral high ground, the human rights framework fails abysmally in protecting humanity from disease as

efficiently as possible. Human rights advocates cling to the moral authority of their system and the individual lives it has saved, but clinging to this failed approach does little to resolve its inefficiencies in providing adequate healthcare. In healthcare, “inefficiencies” are lives lost.