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# The Right to Health: A Duty for Whom?

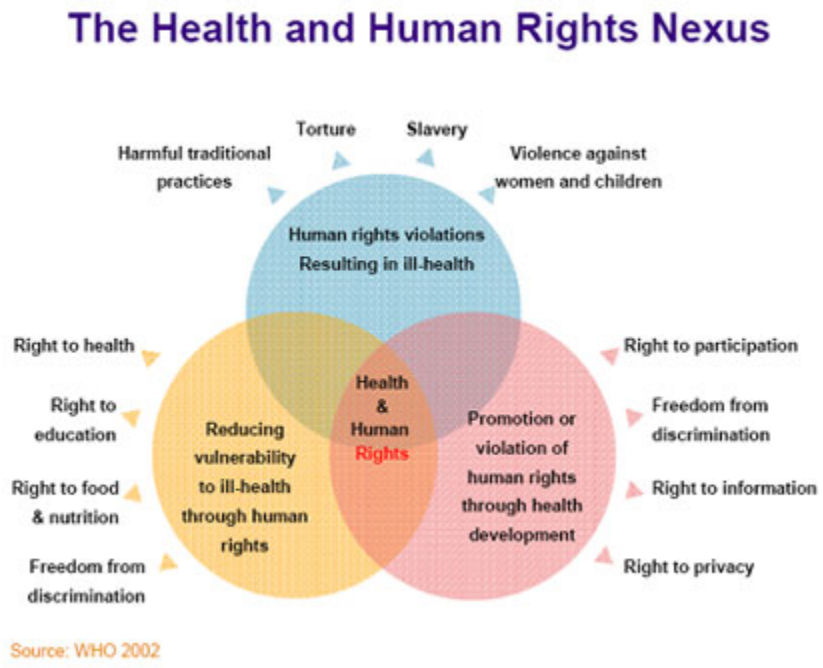
*by Klaus M. Leisinger, Novartis Foundation for Sustainable Development*

**Dr. Klaus M. Leisinger**
**President and Executive Director,**
**Novartis Foundation for Sustainable Development**

The economic, social, and cultural human rights catalogue, including the "right to health", gained increasing importance 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, it is important to point to the fact that rights for which there is a legal obligation for a state may constitute a moral obligation for a non-state actor. For many business enterprises, the nature of a human rights obligation that includes affirmative steps to respect, protect and fulfill human rights in their sphere of influence remains uncharted territory.

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 formulation of the constitution of the World Health Organization (WHO) in 1946 through to the International Covenant and other international human rights treaties, as articulated in the "Health for All by the Year 2000" objective of the Alma-Ata Conference on Primary Health Care in 1978, and as reiterated in September 2000 when the world's leaders adopted the UN Millennium Declaration – is that every human being is entitled to the highest attainable standard of health conducive to living a life in dignity.[3]

The academic "right to health" debate with a powerful political impact took off with an article by Jonathan Mann in 1994.[4] In the context of the ravaging HIV/AIDS pandemic, 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 preferentially 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 leading to lifelong physical, mental, and social effects), and the fact that the promotion and protection of health are inextricably linked to the promotion and protection of human rights and dignity (as in the case of dealing with HIV/AIDS). The interrelatedness and interconnectedness of health and development were prominently acknowledged by setting Millennium Development Goals with specific, measurable health targets.



Although progress can be achieved if the political will is mobilized and if best (or at least good) practices applied, most countries are far from achieving even the goal of reducing child mortality.[5] Meeting the health-related Millennium Development Goals is perceived to be more challenging than the other goals – the least progress has been made on the child and maternal mortality goals and on sanitation.[6] The facts about the current state of human development demonstrate the enormity of the challenges ahead. (See Box 1)

**Box 1: The Poverty Context: The State of Human Development in 2004**

Despite the fact that the last 50 years were the most successful ever in the fight against poverty, the current state of development affairs is characterized by an enormous amount of human misery:[7]
• An estimated 1.17 billion people were living on less than $1 a day in 1999; 2.5–3 billion people were living on less than $2 a day.[8]
• Some 842 million people were undernourished in the period 1999–2001.[9]
• An estimated global total of 1.16 billion people do not have access to improved water sources.
• An estimated global total of 2.36 billion people lack access to adequate sanitation.
• Some 30,000 children under 5 years of age die every day – nearly 500, or two full jumbo jets, during the time it will take to read this position paper. The main causes are dehydration, undernourishment, and preventable diseases.
• Every year more than 500,000 women die in pregnancy and childbirth – one every minute a day.
• More than 42 million people are living with HIV/AIDS, 39 million of them in the developing world.
A regional breakdown shows that sub-Saharan Africa and South Asia are the poverty regions of the world. They account for:
• 69 per cent of global extreme income poverty (315 million people in sub-Saharan Africa and 488 million in South Asia live on less than $1 a day);
• 62 per cent of undernourished people (183 million people in sub-Saharan Africa and 334 million in South Asia);
• 72 per cent of primary-age children not enrolled in school (42 million in sub-Saharan Africa and 40 million in South Asia);
• 78 per cent of under-five mortality (42 per cent of it in sub-Saharan Africa and 36 per cent in South Asia); and
• 480 million people without access to safe water and 1.19 billion without access to adequate sanitation.

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.[10] 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:[11] social stratification – the very fact that people are poor; differential exposure – a greater exposure to multiple health risks (malnourishment, unsafe water, lack of health knowledge, etc.); differential susceptibility – greater vulnerability due to the interactions among multiple health risks; and differential consequences of disease – potentially catastrophic income loss, loss of land or livestock, school dropouts, or other 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 interrelated with and interconnected to progress in the realization of all other civil and political as well as economic, social, and cultural human rights contained in the UDHR, predominantly “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”.[12]

Sustainable progress in the state of health necessitates more than just appropriate health policy and appropriate allocation of resources to a ministry of health. Sustainable health progress depends on and is instrumental for poverty alleviation. Poverty reduction strategies can only be successful if they are followed through 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 and more political impact of 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.[13] 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 more than 500,000 girls and women dying every year – 99 per cent in developing countries – from preventable conditions and injuries related to pregnancy and childbirth. More women than men, at younger ages, are living with HIV/AIDS – about 62 per cent of the young 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 the respect, protection, and fulfillment of human rights in a gender-neutral way would not cost a great deal or many additional resources and would save millions of lives.

High-tech solutions such as the most modern pharmaceuticals are rarely needed to combat typical poverty-related diseases. Better nutrition education for mothers (including the motivation to breast-feed), 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 inexpensive – the combination of these well-known interventions would have a dramatically positive impact on the health of the poor.

Without "development" in the true and comprehensive sense, however, the state of the world's health could deteriorate due to continuing population growth. For despite all the successes reached through social and technological changes, the world's population is likely to reach nearly 9 billion people by 2050 – and about 99 per cent of the population growth will be in the poor regions of the world.[14]

**Bearers of Duties**

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

**Individual Duties.** The state of health of a person and the risks of falling ill are to a great extent determined by individual habits and lifestyles. 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.

**Community Obligations.** Local communities can do much to improve their members' perception of health risks and to reduce them. Functioning communities regard it as their essential obligation[15] to analyze health-related problems and determine their needs and to initiate community efforts and mobilize community resources that will: improve health-related infrastructure such as supplies of safe water, eliminate habitats for vectors that spread diseases and thus interrupt the transmission of the disease, provide community support and care for the needy, and train community workers for health, education, and other items. Significant health results can be achieved without much financial means; even poor communities can achieve a great deal, such as encouraging health-promoting behaviors (breast-feeding, use of mosquito nets, cooking of unsafe water) and developing peer pressure against health risks (unsafe sex, excessive alcohol consumption, violation of women's reproductive rights by men of the community).

**State Obligations.** States have clear and binding obligations under human rights law. As a matter of fact, all human rights are above all incumbent on States and their institutions. States thus do have the prime responsibility to respect, protect, and fulfill their people's right to health. This is interpreted to mean the following:
• *Obligations to respect* include, among other considerations, refraining from denying or limiting equal access for all persons to preventive, curative and palliative health services but also "to refrain from prohibiting or impeding traditional preventive care, healing practices and medicines". (§ 34)
• *Obligations to protect* include, among other considerations, the duties of states 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 parties 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 the 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 the provision of a public, private, or mixed health insurance system that is affordable for all. (§ 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.[16] Once the non-negotiable essentials have been achieved, the continuous national fight for the fulfillment of the health of its citizens must be fought on at least three different fronts:[17]
• 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 do not go to the poorest but to the

better-off;[18] and
• deliver non-medical health interventions, such as training of medical personnel, building of better health information systems, and strengthening of 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.[19] There is mounting evidence that NGOs and the private sector can, at least in some cases, deliver essential and other services to poor people more efficiently than the public sector can.[20]

Although health is widely understood to be both a central goal and an important outcome of development, the importance of investing in health to promote economic development and poverty reduction has been less appreciated. This, despite the fact that "extending the coverage of crucial health services, including a relatively small number of specific interventions, to the world's poor could save millions of lives each year, reduce poverty, spur economic development, and promote global security".[21]

While poor countries, by definition, do have an overall resource scarcity problem, the allocation pattern of available resources is an ongoing issue. Individual countries still spend up to five times as much on the military as on health. (See Box 2)

**Box 2: Public Expenditures on Education, Health, and Military Purposes, Selected Countries, 2000**

| Country | Education (Per cent of GDP, 1998–2000) | Health (Per cent of GDP, 2000) | Military Purposes (Per cent of GDP) |
|---|---|---|---|
| Myanmar | 0.5 | 0.4 | 2.3 |
| Cambodia | 1.9 | 2.0 | 3.0 |
| Pakistan | 1.8 | 0.9 | 4.5 |
| Eritrea | 4.8 | 2.8 | 27.5 |
| Rwanda | 2.8 | 2.7 | 3.9 |
| Burundi | 3.4 | 1.6 | 8.1 |
| Sierra Leone | 1.0 | 2.6 | 3.6 |
| Ethiopia | 4.8 | 1.8 | 6.2 |

Source: UNDP, *Human Development Report 2003*, pp. 297ff.

Violations of the state's obligation to fulfill 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 marginalized.[22] While the International Covenant on Economic, Social and Cultural Rights endeavors to guarantee minimum levels of subsistence to people in poor nations, the principle of "free public health care" continues to be a subject of discussion.

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 competing claims on these resources. Social services (such as free public health services, at least in the context of primary health care) that can be financed by social support services of a mature European nation are well out of reach for any sub-Saharan African nation.

For the sake of a fair discussion of the right to health in a corporate context, it is important to emphasize that in situations where the primary duty of the state is neglected – whether due to a lack of resources (incapability) or deficits in governance (unwillingness) – first and foremost the international community ought to be called to account. With development assistance in case of incapability and with a mixture of pressure and incentives in case of unwillingness, the international community is expected to take joint action to achieve the full realization of the right to health. Richer nations are called on in particular to facilitate access to essential health facilities, goods, and services in poor countries wherever possible and to provide the necessary aid when required.[23]

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

- by calling to account those who are the first and foremost duty-bearers, to help avoid pushing the debate to side issues, thus giving rise to wrong priorities; and
- to avoid the development of unrealistic expectations about sustainable deliverables from the private sector, especially pharmaceutical corporations.

As seen in the context of the heated debate about the "UN Norms on the Responsibilities of Transnational Corporations and Other Businesses on Human Rights"[24], many individuals and major business associations are concerned that where states are incapable or unwilling to fulfill their duties, human rights obligations of the state are pushed on to non-state actors, especially on multinational business enterprises.


**The Obligations of Non-state Actors**

**International Community.** In accordance with Articles 55 and 56 of the Charter of the United Nations, 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 assisting the realization of the right to health at the international, regional, and country levels.

There are a number of relevant binding treaties, such as the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of the Child. In the Millennium Declaration, 147 Heads of State and Government "recognize 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".

Even before that declaration was made, in December 1986 the General Assembly adopted a resolution with regard to the "Right to Development" and proclaimed among other matters that "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". The practical consequences of the commitments made were less than impressive, however.

**Box 3: Donor Assistance on Health, Annual Averages, 1997–99**

| Income Group | Per Person (dollars) | Total (million dollars) |
|---|---|---|
| Least developed countries | 2.29 | 1,473 |

| | | |
|---|---|---|
| Low-income countries[a] | 0.94 | 1,666 |
| Lower-middle income countries[b] | 0.61 | 1,300 |
| Upper-middle income countries[c] | 1.08 | 610 |
| High-income countries[d] | — | 2 |
| All countries | 0.85 | 5,052 |

[a] Per capita GNP <$760. [b] GNP $761–3,030. [c] GNP $3,031– 9,360. [d] GNP > $9,360.
Source: Commission on Macroeconomics and Health, p. 56.

Today, only about 10 per cent of official development assistance goes to health issues – equal to just a penny, 1 cent, of every $100 of donor countries' GNP.[25] This is too little to meet even the basic health needs of poor countries. (See Box 3)

The Commission on Macroeconomics and Health demands that the lack of donor funds not be the factor that limits the capacity to provide health services to the world's poorest people and asks for the commitment of massive additional financial resources for health. The commission estimates that the commitment of an additional $31 billion per year in donor assistance for health by 2015 could – if properly invested – avert 8 million deaths a year, with economic benefits in the magnitude of $360 billion annually.[26] Newer studies suggest an even higher impact of health improvements in the GDP of poor countries.[27]

**NGO Community.** Consultations with poor people reveal that they consider the role of governments to be very important but rather ineffective and sometimes harmful.[28] Problems of corruption emerge as a key issue in poor 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 particular, emergency 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 making human rights an integral dimension of the design, implementation, monitoring, and evaluation of health-related programs.

While NGOs should not be considered as the "silver bullet" for solving all grassroots health problems, they are an important link in the chain. For a sustainable and successful cooperation between NGOs and any other actor – including the private sector – a mutual understanding about respective roles and a perfect "match" is as important as an appropriate climate. Single-issue advocacy pressure groups might not necessarily be among the first partners for cooperation. Whenever pharmaceutical corporations are denounced as a greedy, irresponsible, and socially insensitive crowd of "couldn't-care-less" capitalists, it becomes difficult to expect that the same corporations will queue up to commit their funds and technology. What is needed for sustainable solutions is the pooling of resources, skills, and experience and a spirit of "cooperation in good faith".

**Private Sector.** For the private sector, the prime responsibility 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 endeavors and through resulting innovative ways and means to cure diseases and prevent premature mortality.

Meaningful answers and sustainable commitments require not only differentiating between political and civil human rights and economic, social, and cultural human rights but also defining the boundaries of corporate obligations in a fair societal distribution of responsibility.[29]

Sincere corporate commitments in the context of the right to health – being a positive right whose respect, protection, and fulfillment may require material support beyond what the state is capable or willing to make available – 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, leaving them defenselessly exposed to premature death and preventable sickness.
• On the other hand, to shrug off the "corporate shoulder" and walk away doing nothing in the face of the biggest social problem of humankind is neither a socially nor a morally acceptable option. On the contrary, the situation being as it is presents a challenge and an opportunity for moral leadership and corporate vision. The issue at stake is not "doing something or nothing" but "how much", "in what areas", "for whom", "in partnership with what stakeholders over what period of time", and so on.

A sustainable corporate citizenship approach will carefully examine and decide on the nature and dimension of corporate

obligations. It will also, however, define the boundaries beyond which further corporate contributions are seen as unreasonable. 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:
• essential responsibilities required of any corporation for the respect of the right to health (the “must” dimension);
• additional corporate citizenship standards beyond what is legally required, but excluding corporate philanthropy (the “ought to” dimension); and
• special corporate citizenship endeavors (the “can” dimension).

Consider Novartis as an example. With regard to respect for the right to health, as with all other human rights, Novartis complies within its own sphere of influence with all laws and regulations concerning healthy workplaces, environmental protection, and the safety of products and services.

Being a pharmaceutical corporation, Novartis makes further substantial contributions to the right to health through the results of cutting-edge research, development, and manufacturing of high-quality drugs. This allows the reduction of premature mortality, as well as the prevention or cure of 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 and the state to bear its right-to-health duties.
Novartis, through implementation of its corporate citizenship philosophy, delivers more than just the essentials. This is particularly important in countries where the legal standards are low or not enforced. Through its corporate citizenship endeavors, Novartis strives to make sure that questionable labor standards and environmental practices are avoided. The company adheres to its self-imposed corporate citizenship norms even if local laws and regulations would allow for lower standards. As a responsible company, Novartis aims to avoid benefiting from unhealthy working conditions or unsafe workplaces of third parties within its sphere of influence and to provide assurances about this as far as possible through declarations on the business practices of customers and suppliers.

For employees in the developing world, Novartis has established 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 corporate actions for workers in subsidiaries in the developing world 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.

Novartis is willing to adapt on a case-by-case basis the prices of life-saving medicines for patients living in individual or collective poverty. (Examples of this include the Novartis-WHO cooperation on malaria, which makes the product Coartem available at production cost, and the Gleevec patient’s assistance program.) And in an effort to protect participants of clinical trials all over the world, Novartis adheres to the ethical principles of the Declaration of Helsinki on clinical trials. Last but not least, Novartis is on record for helping out with donations in cases of acute emergency.

Novartis’ deliverables in the context of the “can” dimension comprise actions that are neither required by law nor standard industry practice. They include corporate philanthropy, as well as donations, and are of substantial social or health significance, especially to people living in poverty. In addition, the Novartis Institute for Tropical Diseases is engaged in not-for-profit research to address neglected diseases such as TB and dengue fever.

Corporate philanthropy endeavors, defined as corporate expenditure 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 their fulfillment of their right to health.

For more than 25 years, the Novartis Foundation for Sustainable Development has made significant contributions by investing in projects and programs of development cooperation and humanitarian assistance and has helped increase the effectiveness, efficiency, and significance of project-related aid.[30] In a search for best practices – defined[31] as being innovative, making a positive difference, and having a sustainable effect, as well as the potential to be replicated and serve as a model for generating initiatives elsewhere – the foundation has a long record of contributing to the fulfillment of the right to health of people whose purchasing power does not let them benefit from health services provided through market mechanisms. (For relevant examples see www.novartisfoundation.com.)

**The Fulfillment of the Right to Health as a Multi-stakeholder Task**

Given the huge dimension and complexity of the global health problems in the twenty-first century and taking into consideration the tragic human misery associated with premature death and preventable diseases, the right to health debate is

expected to gain importance. If one considers “health care” as a right, national governments and international institutions are the primary duty bearers to make all reasonable efforts to respect, protect, and fulfill this right. Responsible governments will start with their commitment by making informed decisions to what extent, given the resources available:
• excess mortality and morbidity can be reduced, for example by focusing on interventions that can achieve the greatest health gains possible within the 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 can 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 mosquito nets, the use of condoms as prevention against sexually transmitted diseases, and the fight against tobacco addiction, but also health education for the prevention of cancer and cardiovascular diseases);
• more effective health systems can be developed, for example by setting priorities according to actual needs and giving incentives to improve health sector performance (such as the fact that the known and cost-effective interventions against the diseases that cause 50 per cent of preventable deaths among the poor have been given insufficient priority within existing health systems);[32] and
• investments in expanding the knowledge base can be assured.

Second in the line of duty is the international community. A reality check shows that we are far from being on track with regard to the achievement of the Millennium Development Goals in general and – even more – with regard to health. Midway through the period 1990–2015, the general child and maternal mortality goals are projected to remain unmet almost universally, with sub-Saharan Africa lagging behind most significantly.[33] While part of this can be attributed to lack of good governance, the industrial countries have failed to keep the promises they made at UN conferences in New York (the World Summit for Children, 1990), Cairo (the International Conference on Population and Development, 1993), Copenhagen (the World Summit for Social Development, 1995), Beijing (the World Conferences on Women, 1995 and 2000), Istanbul (the UN Conference on Human Settlements, Habitat II, 1996), and Rome (the World Food Summits, 1996 and 2002). While more than $900 billion is spent for military purposes and nearly $500 billion for protectionist purposes, less than $60 billion goes to development assistance.

Is there a right to health that poor people can call on pharmaceutical companies to sustainably respect? 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 pharmaceutical companies to sustainably protect? Yes, enlightened corporations strive to make sure that questionable labor standards and environmental practices are avoided in their sphere of influence. They adhere to self-imposed corporate citizenship norms even if local laws and regulations would allow for lower standards. Is there a right to health that poor people can call on pharmaceutical corporations to sustainably fulfill? Yes, for those who are employed by the company, through a fair remuneration. But beyond that?

The answer to this key question depends on whom you are asking. 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. Novartis does accept such responsibilities through the “can-dimension” of its corporate citizenship commitment. On its own, however, this cannot be more than a very limited contribution to overcome the challenges that we all face on a global level.

The huge mortality and morbidity burden can, however, 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. The international community’s credibility will be measured in its willingness to deliver on commitments to increase external resources for development. The finance gap for the achievement of the Millennium Development Goals is estimated to be at least $50 billion[34] – tariffs and quotas on agricultural products, textiles, and clothing exported by developing countries are still preventing possible income in the developing countries, while seven times as much is spent on subsidies on the agricultural sector of industrial countries as on global development assistance.

While it is reasonable and fair to expect that business enterprises do not commit, become complicit, or benefit from violations of the political and civil rights of human beings anywhere in the world, the assessment of what is a reasonable and fair contribution to the respect, protection, and fulfillment of economic, social, and cultural rights remains more difficult. This is especially true for the right to health. Novartis’ largest and most sustainable contribution toward this end is and will continue to be through its normal business activities: research, development, manufacturing, and selling pharmaceutical compounds to prevent premature mortality, to cure or alleviate diseases, to prevent or shorten hospitalization, and to contribute to the quality of life of sick people. To do this while adhering to laws and regulations, as well as being in harmony with internationally accepted labor and environment standards, contributes further to the right to health of individuals and enables the state to fulfill its duties.

One thing is, however, obvious: 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 multi-stakeholder approach. This is why all actors of society – be they state or 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 meeting all the Millennium Development Goals – and in fulfilling the right to health.

Link to Endnotes.

*Prof. Dr. Klaus M. Leisinger is President and Executive Director of the Novartis Foundation for Sustainable Development. In addition to his position at Novartis, he teaches and conducts research as Professor of Sociology at the University of Basel. Focus themes include Business Ethics and Globalization, Corporate Social Responsibility of Pharmaceutical Corporations, as well as Human Rights and Business. Dr. Leisinger serves in several advisory functions in different national and international organizations. Affiliations include: United Nations Global Compact, United Nations Development Program (UNDP), World Bank, Asian Development Bank as well as Economic Commission for Latin America (ECLA). He serves as a member of the Board of Trustees of the German Network Business Ethics (Deutsches Netzwerk Wirtschaftsethik), the Arnold Bergstraesser Institut for Research on Politics and Society as well as the Advisory Council of Mary Robinson's Ethical Globalization Initiative. In recognition of his work he was given an honorary doctorate in Theology by the University of Fribourg (Switzerland) in November 2004.*

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