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The Human Right to Health: Whose Obligation?

Doris Schroeder

Introduction

The highest attainable standard of health is a fundamental human right,¹ which has been part of international law since 1948. The preamble to the Universal Declaration of Human Rights states that: ‘*every individual and every organ of society . . . shall strive . . . by progressive measures, national and international, to secure their [human rights] universal and effective recognition and observance*’.²

This chapter analyses and compares obligations vis-à-vis the human right to health of the following groups: governments, affluent individuals, non-governmental organizations (NGOs) and pharmaceutical companies. To focus the discussion, the case of access to life-saving medicines is considered. As the authors of the Millennium Development Goals Gap Task Force have noted, access to medicines is a vital component of realizing the human right to health.³

Nearly 30 per cent of the world population do not have access to life-saving medicines, as Anand Grover reported to the United Nations in 2009. According to him, ‘improving access to medicines could save 10 million lives a year’.⁴ Implied in this mortality figure is immense human suffering. Parents lose their children, children their carer, husbands their wives. And a mortality figure does not even capture the additional suffering associated with avoidable ill health and morbidity.

Who are the individuals and organs of society, who must strive to secure the universal and effective recognition of human rights, in particular the human

1 Henceforth, ‘Human Right to Health’.

2 Universal Declaration of Human Rights 1948: Preamble, emphasis added; available at www.un.org/en/documents/udhr/index.shtml#a25

3 United Nations MDG Gap Task Force, *Delivering on the Global Partnership for Achieving the Millennium Development Goals* (New York: United Nations, 2008), 42.

4 Anand Grover, *Promotion and Protection of All Human Rights, Civil, Political, Economic, Social and Cultural Rights, Including the Right to Development, a Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, U.N. Doc. A/HRC/11/12 (New York: United Nations, 2009), 6, 7, 28.

right to health and its sub-goal, the human right to access life-saving drugs? Figure 12.1 captures the essence of the question, which will occupy us for the remainder of this chapter.

Governmental obligations

The one entity from our set of potential duty holders that undisputedly carries obligations towards the human right to health are governments. Governments or states have legal obligations to respect, protect and fulfil the right to health, which includes assuring access to life-saving medicines for all and – for developed countries – providing international assistance. The relevant legal instruments which enshrine the above obligations are listed in Table 12.1.

With reference to access to life-saving medicines, Anand Grover makes it clear that these fall squarely within state obligations. He writes:

States have an obligation under the right to health to ensure that medicines are available, financially affordable, and physically accessible on a basis of non-discrimination to everyone within their jurisdiction. Developed States also have a responsibility to take steps towards the full realization of the right to health through international assistance and cooperation.⁵

The reason state obligations are stringent is that they are contractual. States have committed themselves to abiding by these obligations through binding legislation such as the International Covenant on Economic, Social and

Figure 12.1 The human right to health – whose obligation?

⁵ Ibid.

Table 12.1 The human right to health – relevant legal instruments

Government obligations towards their own citizens	Government obligations for international assistance
<ul style="list-style-type: none"> ○ Universal Declaration of Human Rights, Art.25(1)^a ○ International Covenant on Economic, Social and Cultural Rights, Art.12^b ○ Convention on the Elimination of All Forms of Discrimination against Women, Art.12^c ○ Convention on the Rights of the Child, Art.24(1–3)^d 	<ul style="list-style-type: none"> ○ Declaration of Alma-Ata, Art.II^e ○ UN Committee on Economic, Social and Cultural Rights E/C.12/2000/4, General Comment No.14.^f ○ Millennium Development Goals 4, 5 and 6^g ○ Convention on the Rights of the Child, Art.24(4)^h

a www.un.org/en/documents/udhr/.

b www2.ohchr.org/english/law/cescr.htm.

c www.un.org/womenwatch/daw/cedaw/text/econvention.htm.

d www2.ohchr.org/english/law/crc.htm.

e www.who.int/hpr/NPH/docs/declaration_almaata.pdf.

f [www.unhchr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En](http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En).

g www.un.org/millenniumgoals/bkgd.shtml.

h www2.ohchr.org/english/law/crc.htm.

Cultural Rights. However, it is noteworthy that the United States of America, South Africa and Cuba have not ratified the Covenant.⁶ Hence, there are some exceptions. Likewise, the United States and Somalia have not ratified the Convention on the Rights of the Child. But with the exception of the United States, the duties towards one's own and other countries' citizens that derive from the above legal instruments are widely accepted, if judged on accession and ratification. However, a more detailed comparison of ratification with human rights commitment is not encouraging.

In 2009 the Lancet published a study which assessed whether the ratification of human rights treaties was linked to improved health indicators. The study analysed

data for health (including HIV prevalence, and maternal, infant, and child [<5 years] mortalities) and social indicators (child labour, human development index, sex gap, and corruption index), gathered from 170 countries. [The results] showed no consistent associations between ratification of human-rights treaties and health or social outcomes.⁷

6 See: http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&cmdsg_no=IV-3&chapter=4&lang=en.

7 Alexis Palmer, Jocelyn Tomkinson, Charlene Phung, Nathan Ford, Michel Joffres, Kimberly A. Fernandes, et al., 'Does ratification of human-rights treaties have effects on population health?', *The Lancet*, 2009, 373(9679): 1987–92.

Thus, pinpointing who has a stringent obligation to secure the human right to health for all does not by itself mobilize sufficient resources or willingness. However, recent developments in international ‘soft law’, that is non-binding law, may help expand the group of agents who have stringent obligations and may therefore be mobilized alongside governments.

Affluent individuals’ obligations

In general, human beings value life and want to enjoy its full length from childhood to adulthood to seniority. In recognition of this human *joie de vivre*, heroic life-saving acts occur all over the world. For instance, in New York, Wesley Autrey jumped onto a subway track to help a fallen teenager when a train was approaching. Unable to hoist the unresponsive teenager onto the platform, he decided to cover him with his body and lie still in the drainage trough while the train passed. Both men survived. Autrey later commented: ‘I don’t feel like I did something spectacular; I just saw someone who needed help. I did what I felt was right.’⁸

Yet, while a heroically courageous man feels that rescuing a complete stranger is simply the right thing to do, the essence of such an act rarely translates into rescuing the lives of *distant* strangers. ‘We can reasonably believe that the cost of saving a life through . . . [specified] charities is somewhere between \$200 and \$2000.’⁹ This aligns roughly with the costs of providing patent-protected drugs to AIDS patients. In 2008, the yearly cost of providing second-line¹⁰ anti-retrovirals was \$US 1,105 per patient in low-income countries.¹¹ This means that affluent individuals could regularly save other people’s lives without major restrictions on their own.

The question how much the relatively well off are obligated to do for the needy is one of the most interesting areas . . . in moral theory . . . We frequently wonder whether we are doing what morality requires of us in terms of helping others. And it is far from obvious that any familiar moral theory has an intuitively acceptable line on this matter.¹²

Brad Hooker, the author of the above excerpt, is right. Intuitively acceptable answers on this matter are not easily available. Table 12.2 therefore simplifies some relevant answers.

8 See: www.msnbc.msn.com/id/16444249/.

9 Peter Singer, *The Life You Can Save* (Melbourne: Text Publishing, 2009), 111.

10 Second-line drugs are used when the standard therapy fails, and are often much more expensive than the first drug of choice.

11 Avert, *Aids, Drug Prices and Generic Drugs*.

12 Brad Hooker, *Ideal Code, Real World* (Oxford: Clarendon Press, 2000), 159.

Table 12.2 Why promote distant strangers' human right to health?

Author	Principle	The case of life-saving medicines
Peter Singer	'If it is in our power to prevent something bad from happening, without thereby sacrificing anything of comparable moral importance, then we ought, morally, to do it.' ^a	The death of 10 million people p.a. from lack of access to medicines is a typical case for the application of Singer's utilitarian principle. Affluent individuals can prevent something bad from happening without sacrificing anything of comparable moral importance by, for instance, donating to charity.
Immanuel Kant	'Act only according to that maxim whereby you can, at the same time, will that it should become a universal law.' ^b	One cannot universalize a maxim that lets 10 million people die every year unnecessarily because the affluent refuse to assist the poor. No reasonable person would want to live in this world.
Aristotle	'... happiness is an activity of soul in accordance with perfect virtue.' (1102a) ^c	Generosity is a virtue situated between wastefulness and meanness. In order to achieve happiness through perfect virtue, it is important not to be mean; more important than not to be wasteful. Hence, one should err on the side of giving too much to benefit others.

^a Singer, Peter (2009) *The Life You Can Save*, Melbourne: Text Publishing.^b Kant, Immanuel (1965, 1785) *Grundlegung zur Metaphysik der Sitten*, Hamburg: Felix Meiner Verlag, 42 (421).^c Aristotle (1985) *Nikomachische Ethik*, Hamburg: Felix Meiner Verlag, 22 (1102a).

As Table 12.2 shows, Singer, Kant and Aristotle provide good philosophical reasons for requiring affluent individuals to take action on securing the human right to health for the global poor. However, while some philosophers believe that our duties towards distant strangers are nowhere near this pressing,¹³ there

13 See, for instance, Warwick Fox who argues that we only have one duty towards distant others, namely not to harm them. When it comes to providing assistance, Fox distinguishes between strong duties of benevolence one has towards one's partner, children and close relatives ('supersignificant others') from weaker duties towards one's friends, close colleagues or mentors ('significant others'). To distant others, we have no duties of benevolence, he argues (*A Theory of General Ethics: Human Relationships, Nature, and the Built Environment* (Cambridge, MA: MIT Press, 2007)).

is an even more obvious reason why affluent individuals have no stringent¹⁴ obligation to help secure the human right to health for others. Benevolence and charity, as requested by all three of the above philosophers, leave considerable space for individual decision-making. If an affluent individual decides to spend her resources on improving food security for the global poor to the neglect of their health-care needs, she still fully complies with her moral obligations. Hence, there is no philosophical justification for requiring any particular affluent individual to help secure universal and effective recognition and observance of the human right to health per se. As long as the individual does *something* to relieve the burden of suffering from the poor, relative to her means, all is well, morally speaking.

Contrary to the above, Thomas Pogge offers a justification for a stringent obligation on why affluent individuals *must* assist the global poor in their right to access to life-saving medicines. We are not faced here with a question of beneficence, that is of how philanthropy ought to set in to rescue a distant stranger. As Pogge puts it: 'we are not bystanders who find ourselves confronted with foreign deprivations whose origins are wholly unconnected to ourselves.'¹⁵ We are benefactors of an intellectual property rights framework that systematically favours our interests and the interests of the pharmaceutical industry over those of 'desperately poor people, often stunted from infancy, illiterate and heavily preoccupied with the struggle to survive, [who] can do little by way of either resisting or rewarding their local and national rulers, who are therefore likely to rule them oppressively while catering to the interests of other (often foreign) agents'.¹⁶

It is important here to consider Anand Grover's judgement on the causes for 10 million deaths per year. He noted that:

the inability of populations to access medicines is partly due to high costs¹⁷ [. . . as] TRIPS and FTAs [Free Trade Agreements] have had an adverse impact on prices and availability of medicines, making it difficult for countries to comply with their obligations to respect, protect, and fulfil the right to health.¹⁸

It is therefore clear that the current intellectual property rights system, which Pogge singles out as one reason for imposing a duty on affluent individuals, does indeed contribute to these 10 million deaths each year.

To sum up this section, while traditional philosophical theories on beneficence cannot justify a stringent obligation that affluent individuals must

14 By stringent, I mean an obligation that cannot be avoided without failing in one's duties as a moral agent. One could also use the Kantian term 'perfect duty'. Immanuel Kant, *Grundlegung zur Metaphysik der Sitten* (Hamburg: Felix Meiner Verlag, 1965, [1785]), 43 (421).

15 Thomas Pogge, 'Priorities of Global Justice', in Thomas Pogge (ed.), *Global Justice* (Oxford: Blackwell Publishers, 2001), 14.

16 *Ibid.*, 8.

17 Grover, *Promotion and Protection of All Human Rights*, 7, point 14.

18 *Ibid.*, 28, point 94.

assist in securing the human right to access to life-saving medicines, Pogge's philosophical insight and Grover's confirmation of the detrimental effects of the international intellectual property rights system lead to a different conclusion. As benefactors of a system that tailors medicines to diseases of the affluent who can afford monopoly prices, while foreseeably harming the poor,¹⁹ we do have a specific duty to help the poor access life-saving medicines. It is a duty that stems from a combination of benefits received with harm foreseeably done rather than our obligations of beneficence. I shall return to this topic when discussing the obligations of pharmaceutical companies.

NGO obligations

The term non-governmental organization (NGO) is used in many different settings for a wide range of bodies. Yet, some features are common to all. An NGO must:

- be independent from direct government control;
- not constitute a political party;
- be non-profit-making; and
- be non-violent.

The above characteristics are required for recognition by the United Nations. An NGO can therefore be understood as:

an independent voluntary association of people acting together on a continuous basis, for some common purpose, other than achieving government office, making money or illegal activities.²⁰

At first hand, it may seem obvious that some NGOs have obligations to help the 10 million who currently die from lack of access to life-saving medicines. They would then be one of the organs of society, which are meant to strive to secure the human right to health for all. Organizations such as *Médecins Sans Frontières*, the Clinton Foundation, the Medicines for Malaria Venture, or the Foundation for Innovative New Diagnostics are already working towards this aim highly successfully. However, voluntary organizations can by their very nature not have any *stringent* or to use Kant's term *perfect* obligations to secure a particular common good.

19 Aidan Hollis and Thomas Pogge, *The Health Impact Fund: Making New Medicines Accessible for All* (Incentives for Global Health, 2008).

20 Peter Willetts, *What is a Non-Governmental Organization?* (UNESCO Encyclopaedia of Life Support Systems, 2002) Section 1: www.staff.city.ac.uk/p.willetts/CS-NTWKS/NGO-ART.HTM#Part1.

The above-named NGOs may have relevant mission statements. For instance, the Medicines for Malaria Venture envisions ‘a world in which . . . innovative medicines will cure and protect the vulnerable and under-served populations at risk of malaria, and help to ultimately eradicate this terrible disease’.²¹ But their efforts are truly voluntary and charity-based. That they have chosen to collaborate on ventures to secure the human right to health is supererogatory rather than obligation-based. They fall under the precept that was discussed above for affluent individuals, namely that we may all have duties of beneficence but how we discharge them is up to us. No affluent individual and no NGO can be forced, morally, to undertake charitable efforts in a particular area.²² At the same time, the Poggean argument of benefitting from a system that imposes foreseeable harm on the poor cannot be made with regard to NGOs. Hence, there is no stringent obligation upon NGOs to help secure the human right to health.

Pharmaceutical industry obligations

The main role of a pharmaceutical company is to develop and produce innovative drugs and services that improve the quality of life of patients. No other societal actor assumes this responsibility as their main task. Paul Hunt, Anand Grover’s predecessor as UN Special Rapporteur on the right to health formulates it thus:

A pharmaceutical company that develops a life-saving medicine has performed a vitally important medical, public health and right-to-health function. By saving lives, reducing suffering and improving public health, it has not only enhanced the quality of life of individuals, but also contributed to the prosperity of individuals, families and communities. The company, and its employees, has made a major contribution to the realisation of the rights to life and the highest attainable standard of health.²³

Yet beyond this traditional role, increasing demands are made on pharmaceutical companies to recognize and fulfil further obligations in relation to the right to health. This development became most obvious with the adoption of the Millennium Development Goals (MDGs). MDG 8 Target E requires that governments ‘in cooperation with *pharmaceutical companies*, provide access to

21 See: www.mmv.org/about-us.

22 Of course, if an NGO has already announced its mission and collected relevant donations, it may be bound to particular efforts, but I am here talking about formulating mission statements in the first place.

23 Paul Hunt, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health: Annex – Mission to Glaxosmithkline* (New York: United Nations, 2009), 11: 35.

affordable essential drugs in developing countries'.²⁴ While the private sector in general is mentioned elsewhere (e.g. MDG 8F), no other industrial sector is named explicitly. Likewise a Lancet editorial assigns responsibilities to the pharmaceutical sector:

Almost 2 billion people worldwide lack access to essential medicines. The human rights responsibility to improve access lies mainly with the state. However, non-state actors, such as the pharmaceutical industry, share that responsibility too.²⁵

Additional pressure comes from NGOs. In *Investing for Life – Meeting poor people's needs for access to medicines through responsible business practices*, Oxfam states:

there are major shortcomings in the pharmaceutical industry's current initiatives to ensure that poor people have access to medicines . . . The time is ripe for a bold new approach. The industry must put access to medicines at the heart of its decision-making and practices . . . The industry's failure to comprehend access to medicines as a fundamental human right enshrined in international law, and to recognise that pharmaceutical companies have responsibilities in this context, has prevented the adoption of appropriate strategies.²⁶

The remainder of this section examines whether and if so how the above demands could be philosophically justified. Does the pharmaceutical sector have a co-responsibility, together with governments, to fulfil the human right to health?²⁷

The starting point for an investigation of the above question has to be the international intellectual property rights system, and more particularly patents. Patents bar entry to the market for products copied from the original for a specified interval so that innovators can recoup research and development costs through charging monopoly prices.²⁸ Among those who benefit from intellectual property rights protection, the pharmaceutical industry is the

24 See: www.un.org/millenniumgoals/global.shtml.

25 Editorial, 'Right-To-Health Responsibilities of Pharmaceutical Companies,' *The Lancet*, 2009, 373: 1998.

26 Oxfam. *Investing for Life – Meeting Poor People's Needs for Access to Medicines through Responsible Business Practices* (Oxfam Briefing Paper 109, 2007), 1: www.oxfam.org/sites/www.oxfam.org/files/bp109-investing-for-life-0711.pdf.

27 I shall take it for granted that pharmaceutical companies *respect* the human right to health and, for instance, do not harm their employees in unsafe working conditions or undertake trials on human participants with an unjustifiable harm–benefit ratio; This section is based on: Doris Schroeder, 'Does the Pharmaceutical Sector have a Co-Responsibility to Secure the Human Right to Health?', *Cambridge Quarterly of Healthcare Ethics*, 2011, 20(2): 298–308.

28 P. M. Danzon and A Towse, 'Differential Pricing for Pharmaceuticals: Reconciling Access, R&D and Patents', *International Journal of Health Care Finance and Economics*, 2003, 3: 183–205, 185.

only industry that trades in goods that are required to satisfy basic human needs.²⁹

Films, software, books, designs, circuit layouts, computer programs, etc. – none of these satisfy basic human needs. The only exception is the seeds industry, which does benefit from intellectual property rights protection while providing for basic human needs. However, considerable farmers' rights against multinational corporations have been established under the International Treaty on Plant Genetic Resources for Food and Agriculture (ITPGR). This treaty exempts a number of basic food and seed crops from patenting and makes them accessible to all member states through a facilitated system.³⁰ There are no such exemptions for the pharmaceutical industry, and countries face serious difficulties when they invoke the compulsory licensing exemption³¹ of the Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement.³² Hence, the pharmaceutical sector is unique in benefiting from monopoly pricing powers at the same time as providing for a basic human need. However, the justification for pharmaceutical obligations is more subtle than a benefit granted through patents on the one hand and access to medicines for the poor on the other. The most obvious response would be that innovators have a human right to the protection of their invention, which is of equal standing to the human right to life of the poor. This claim has been discussed elsewhere and it was shown that the right to life trumps when colliding with the natural right to intellectual property protection.³³

Given Anand Grover's statement that TRIPS 'had an adverse impact on prices and availability of medicines, making it difficult for countries to comply with their obligations to respect, protect, and fulfil the right to health',³⁴ would one not need to question intellectual property rights in general? In particular, if they cannot be maintained against the right to life of the poor? If 'patents are killing people',³⁵ should the system not be abandoned rather than maintained to secure profits for the pharmaceutical industry?

29 In line with Art. 25(1) of the Declaration of Human Rights I take basic human needs to comprise: food, clothing, housing and medical care.

30 Laurence R. Helfer, *Intellectual Property Rights in Plant Varieties – International Legal Regimes and Policy Options for National Governments*, FAO Legislative Study 85 (Rome: United Nations, 2004), Part IV.

31 With a compulsory license, a government forces a patent holder to allow the manufacture of generic copies of a drug at significantly reduced prices.

32 SciDevNet, Drug Licences All for the Poor, Says Thai Minister: www.scidev.net/en/news/drug-licences-all-for-the-poor-says-thai-minister.html.

33 Doris Schroeder and Peter Singer, 'Access to Life-Saving Medicines and Intellectual Property Rights – An Ethical Assessment', *Cambridge Quarterly of Healthcare Ethics*, 2011, 20(2): 279–89.

34 Grover, *Promotion and Protection of All Human Rights*, 28, point 94.

35 Madeleine Bunting, Profits that Kill, *The Guardian* (2001): www.guardian.co.uk/world/2001/feb/12/wto.aids.

The obvious answer to this question is that profits for the pharmaceutical industry are not the main justification for the patent system. As stated in the preamble of the 1970s Patent Cooperation Treaty, which covers 142 countries,³⁶ the reason governments support intellectual property rights is because patents ‘make a contribution to the progress of science and technology’ and ‘facilitate and accelerate access by the public to the technical information contained in documents describing new inventions’.

While patents are ‘a tortured solution to the problem of providing a public good’,³⁷ it is not yet clear that there is an alternative. Providing a public good in the form of a product that is cheaply and easily copied, yet requires significant investment, is highly difficult, although efforts are being made.³⁸ This does not mean that the system could not be improved³⁹ or that the pharmaceutical industry cannot be assigned a special obligation towards the human right to health given their considerable benefits from a system that foreseeably harms the poor. This argument from harm was already discussed in the section on affluent individuals. In the case of the pharmaceutical industry, the argument is even stronger as it has more recently benefitted from a system change (the adoption of TRIPS) that is less relevant to affluent individuals (at least in the North) than it is to industry.

For example, before the adoption of TRIPS, Indian law only allowed patents on processes, not on products. As a result, India had a thriving generic pharmaceuticals industry that supplied copies of patented medicines cheaply throughout the world’s poor regions. However, in 1994 India signed up to TRIPS and as a result, was required to introduce patents on products by January 2005. This change to Indian patent rules affects the world’s poor in two ways; directly by undercutting the supply of affordable medicines and indirectly by removing the generic competition that reduced the cost of brand-name medicines.⁴⁰ These poor populations are now worse off and possibly dying, due to a tightening of the existing intellectual property system. At least some of the 10 million avoidable annual deaths alluded to above can be attributed to current developments in the patent system. Hence, we can speak of a direct, recent harm, which relates to the patent system and which could have been avoided without the adoption of the TRIPS agreement. The

36 World Intellectual Property Organization, Treaties and Contracting Parties: www.wipo.int/treaties/en/ShowResults.jsp?lang=en&treaty_id=6.

37 Suzanne Scotcher, *Innovation and Incentives* (Cambridge, MA: MIT Press, 2004), 34.

38 Carl Nathan, ‘Aligning Pharmaceutical Innovation with Medical Need’, *Nature Medicine*, 2007, 13(3): 304–8; Josephine Johnston and Angela A. Wasunna, ‘Patents Biomedical Research and Treatments – Examining Concerns, Canvassing Solutions’, *A Hastings Centre Special Report*, 2007, 37(1): S1–S36.

39 See for instance, Hollis and Pogge, *The Health Impact Fund: Making New Medicines Accessible for All*.

40 Editorial, ‘India’s Choice’, *New York Times* (2005), www.nytimes.com/2005/01/18/opinion/18tues2.html.

argument that patents are a tortured solution to providing a social good, but alas necessary, does not work for those poor who may die due to the TRIPS regime. Prior to its adoption, pharmaceutical companies researched, developed and produced medical interventions. It was not necessary to adopt TRIPS to provide incentives for pharmaceutical research. But again, the problem is more subtle than this.

High prices of drugs under patent protection are not the only problem endangering poor people's health. Given that the pharmaceutical industry operates almost exclusively within the profit-making sector in line with its primary obligation in a market system (to develop and produce innovative drugs and services that improve the quality of life of patients), diseases that burden the poor are often not investigated in the first place. One can therefore speak of an accessibility problem (i.e. that existing drugs are priced beyond the reach of the poor) and an availability problem (i.e. that drugs are not being developed to address the needs of the poor).⁴¹ It is assumed that stronger patent protection in countries like India, Brazil and South Africa will lead to the growing interest of pharmaceutical companies in so-called neglected diseases, given that purchasing power in those countries is significantly on the increase. Hence, while TRIPS creates direct harm for those poor people who can no longer access cheap generic copies of patented drugs in, say India today, it contributes (at least potentially) to resolving the neglected diseases issue. Going back to the pre-TRIPS regime is therefore no straightforward solution, morally, if one considered future benefit. At the same time, the pharmaceutical sector benefits from a system that imposes direct harm, for instance on the current severely poor in India who would have had access to generic copies of patented drugs without TRIPS.

Corporate social responsibility is usually discussed within the realm of law, enlightened self-interest or benevolence. Either a duty is instructed by law (e.g. health and safety for workers) or self-interest (e.g. continuing education of staff) or benevolence (e.g. donations) or a mixture of the three. But for one business sector, namely those companies that benefit from patents on goods required to satisfy basic needs, a fourth realm must be added; namely a duty of redress for harm from which one benefits.

What follows from this? The creators of the international intellectual property rights system are policy-makers, pressured by lobbyists, among them the pharmaceutical industry. The strongest duty to reduce any foreseeable harm from the current patent system lies with its creators, who have to fine-tune the system to a degree of maximum benefit and minimum harm. One possibility

41 Michael J. Selgelid and Eline M. Sepers, 'Patents, Profits, and the Price of Pills: Implications for Access and Availability,' in P. Illingworth, U. Schuklenk and J. C. Cohen (eds), *The Power of Pills: Social, Ethical and Legal Issues in Drug Development, Marketing and Pricing Policies* (London: Pluto Press, 2006), 153.

is the Health Impact Fund, a reform plan suggested by a team working with Thomas Pogge,⁴² and discussed alongside alternative possibilities in Sadie Regmi's chapter in this volume.

At the same time, the system has not only creators, but also beneficiaries, most notably the pharmaceutical industry and those who are affluent enough to enjoy the fruits of scientific progress. Duties of redress for harm imposed on some which achieves benefits for others, apply to both these groups. It is here that one can most reasonably apply the Kantian 'ought implies can'⁴³ maxim. Pharmaceutical corporations in affluent countries are better placed than civil society to have a fast impact on the health of the poor. They must therefore discharge their responsibility to reduce the harm generated by a system from which they benefit, that is, this is not a supererogatory act.

Conclusion

Each year, 10 million people die unnecessarily, because they have no access to life-saving drugs. To provide such access is generally regarded as a government obligation. Ignoring the notable exception of the United States, almost all states world-wide have accepted this obligation through ratification of relevant human rights instruments. The Millennium Development Goals have added to these instruments by requiring the pharmaceutical industry to help provide access to affordable essential drugs in developing countries. This imposition of duties on industry can be morally justified, while an equivalent duty on affluent individuals and NGOs cannot. Pharmaceutical innovation is the only research activity protected through patents, which targets basic human need satisfaction. As such it is the only research activity, which benefits from intellectual property rights protection while foreseeably harming the poor. Abolishing patents is not the answer, yet giving the industry a share in fulfilling human rights could be. How far this will improve on governments' track record to fulfil the human right to health remains to be seen. Novartis' long-term commitment to leprosy-elimination could point the way.⁴⁴

42 See <http://healthimpactfund.com>

43 'He must judge that he *can* do what the law imposes on him unconditionally that he *ought* to do.' Kant, Immanuel (1990, [1797]) *Metaphysische Anfangsgründe der Tugendlehre*, Hamburg: Felix Meiner Verlag, 12 (380), my translation.

44 www.novartisfoundation.org/page/content/index.asp?MenuID=217&ID=493&Menu=3&Item=43.2.