Comment on Jennings, 'Right Relation and Right Recognition in Public Health Ethics: Thinking through the Republic of Health'

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This paper offers a brief comment on Jennings' preceding paper, focusing on the capacity of a republican approach to public health ethics to facilitate reconceptualization of the right to health in situations of limited resources through a relational reading.

In the preceding paper, Bruce Jennings makes a powerful case for further evolution of the normative conceptual discourse of public health ethics in a manner which is consonant with the republican tradition. In this brief commentary, I wish to argue that adoption of this richer mode of expressing and understanding our lived moral experience can facilitate the rethinking of two related and fundamental—but presently problematic—concepts and features which are germane to a central topic in public health ethics: how to secure justice in the allocation of scarce resources.

Rights

The extent to which human rights; in particular, the human right to health, sit comfortably within public health ethics and policy is a matter of considerable debate. Some see the two as mutually complementary: Annas (1998: 1780) argues that 'the unification of public health and human rights efforts throughout the world could be a powerful force to improve the lives of every person'. Others are much more sceptical as to the utility of rights in this context: for example, O'Neill (2002: 42) contends that 'taking rights as basic to ethics, including health ethics, does not get close enough to the action'. This equivocation also finds expression in the practice of public health: for example, Médecins sans Frontières have traditionally avoided utilizing human rights rhetoric (Redfield, 2008: 139), and it has been noted that there is no direct correlation between ratification of human rights treaties and improved population health outcomes (George *et al.*, 2010).

There are a number of reasons for the uncertain position of human rights which cannot be surveyed in a commentary of this brevity. However, of central significance is the assumed individualistic orientation of rights, reflected in Meier's (2007: 545) claim that 'the right to health has been ineffective in compelling states to address burgeoning inequalities in underlying determinants of health, focusing on individual medical treatments at the expense of public health systems'. This underpins the perception that litigation grounded in rights tends to privilege middle-class demands for expensive clinical treatments and that this reduces the capacity to finance population-based preventive measures, although it has been cogently argued that there is insufficient evidence to demonstrate that this is always the case (Yamin, 2011: 352).

In his account of liberty, Jennings exhorts us to move away from individualistic discourse and to understand the concept in a relational manner, stressing that this is about more than mere balancing against other conflicting values and norms. The vision which Jennings embraces—'not so much a situation of freedom from interference by others as a situation of freedom through capability-enhancing relationships with others' (2015: xx)—is palpably distinct from the hegemonic Kantian approach to autonomy which forms the 'very essence of human rights' (Woodiwiss, 2005: 11). Yet, as Nedelsky (1993: 13) reminds us, 'what rights do and have always done is construct relationships—of power, of responsibility, of trust and obligation . . . in defining and enforcing rights, the law routinely structures and sometimes self-consciously takes account of relationship'. Reconfiguration of rights in a relational direction,

while not straightforward, is thus certainly not infeasible. Such a development would significantly enhance the capacity of the right to health to be utilized in pursuit of amelioration of population health goals and the determinants of health, as it would be predicated on notions of interconnectedness. This would facilitate a broadening of the moral focus beyond personal responsibility to wider social conditions and pursuit of the common good (Wallack and Lawrence, 2005).

Resources

It is widely accepted that the setting of priorities—or ‘rationing’—is a necessary response to the mismatch between the demand for, and supply of, resources for health. As noted above, this process may sit uneasily with claims expressed via the norms and discourse of rights. For example, Daniels (2008: 314) views the need to set priorities as ‘one of the important blind spots’ of the human rights movement. Similarly, the former UN Rapporteur on the Right to Health has observed that the human rights community has not given prioritizing and rationing ‘the sustained attention they deserve’, with some arguing that ‘the human rights community should not involve itself in issues of prioritisation’, given the propensity of the latter to favour the wealthy and marginalize the disadvantaged (UN General Assembly, 2007).

The correlation between rights and rationing was explored in the Constitutional Court of South Africa case of *Soobramoney v Minister of Health (KwaZulu-Natal)*. While the case was determined on the basis that the constitutional right to access health-care services was lawfully limited by the resources available to the state, Justice Albie Sachs offered an original perspective on the relationship, viewing rationing not (as is usually the case) as antithetical to the realization of the right, but rather as ‘integral’ to it, as ‘defining the circumstances in which the right may most fairly and effectively be enjoyed’. The judge argued that rights in the health-care context demanded consideration not merely as structured around autonomy, but instead:

in a new analytical framework based on the notion of human interdependence. A healthy life depends upon social interdependence: the quality of air, water, and sanitation which the state maintains for the public good; the quality of one’s caring relationships, which are highly correlated to health; as well as the quality of health care and support furnished officially by medical institutions and provided informally

by family, friends, and the community (*Soobramoney*, 1997: 52–54).

Writing elsewhere, he confessed that he was unsure as to the implications of such an approach as regards conceptualization of the right to health (Sachs, 2003: 592). Such uncertainty may be seen as reflective of a broader failure fully to clarify the normative foundations of the right (Yamin, 2011: 358).

Once again, the relational approach offers scope for addressing such concerns. As Jennings notes (2015: xx), it moves the debate away from the ‘distribution of resources... [to] the use of resources to achieve the human good’. The (limited) resources which are available may be seen as an aspect of the ‘health commons’, whose ‘nature and... essence is the sharing’ and which is characterized by a ‘web of interdependence’. Understood in this way, rationing or prioritization does not amount to a restriction on the realization of a right. Rather, those rights are relational and are founded upon mutuality, in which the conditions of others are linked to the condition of the self. Rationing is therefore necessary, given conditions of scarcity, to best secure the health of a community in which the social being is ultimately constituted through its embeddedness therein.

Conclusion

Here, then, is the ‘new analytical framework’ for which Sachs calls. Of course, as Jennings acknowledges (2015: xx), a relational reconfiguration of the right to health and the relationship of resources to it will ‘not be the work of a day’, especially given the hegemonic status of the individualistic reading of autonomy which undergirds the discourse and practice of human rights. Yet, given the lack of clarity surrounding the normative foundation of the right to health and the difficulty of correlating it with the inevitable scarcity of resources, the task is surely one worth undertaking. Jennings has provided us with an initial agenda: much work remains to be done to take that agenda forward.

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