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From a Bounded View to a Globalized Perspective: Considerations on a Human Right to Health

Abstract: In this essay, I will argue that even when there are important difficulties concerning the possibility of a human right to health that must be addressed, it is nonetheless a better strategy for promoting global health than the ones relying entirely on States' duties or on a duty to charity. The idea that there is such thing as a right to health is very controversial. One of the most important difficulties has been to determine if a right to health can be considered as a human right, as an institutional right or just as a humanitarian charitable cause. Which of these we take it to be will shape the possibility of a global demand for health.

The idea that there is such thing as a right to health is very controversial, and “there is no single universally agreed-upon interpretation of the right to health.” (Lawrence 2014, p. 257) One of the most important difficulties has been to determine if a right to health can be considered as a human right, as an institutional right or just as a humanitarian charitable cause. Which of these we take it to be will shape the possibility of a global demand for health.

One can argue that, in fact, there is already a human right to health, stated in the Universal Declaration of Human Rights. Article 25 (1) of the Universal Declaration states that:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. (UN General Assembly 217 A (III), art. 25(1))

Another formulation of the human right to health is provided by article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which states that everyone has the right to “the enjoyment of the highest attainable standard of physical and mental health.” (United Nations, Treaty Series, vol. 993, art. 12) The ICESCR points out that this goal can be achieved by provid-

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ing medical care for all, assuring the improvement of environmental conditions, reducing the stillbirth-rate and infant mortality, and with prevention and treatment of epidemic, endemic, occupational and other diseases (United Nations, Treaty Series, vol. 993, art. 12).

Despite being recognized as such by the Universal Declaration and being reaffirmed by the ICESCR, there have been many arguments that intend to show that both formulations are too vague, too demanding or even damaging (Wolff 2012a), and that consequently, they do not offer a good account of what a human right to health could be. Although the ICESCR offers us a more precise account, both formulations face several problems and have been considered as posing a spurious demand that cannot be legitimately considered as a human right.

In this essay, I will argue that even when there are important difficulties concerning the possibility of a human right to health that must be addressed, it is nonetheless a better strategy for promoting global health than the ones relying entirely on States' duties or on a duty to charity. To show this, I will present two strong objections that have been made against the possibility of a human right to health. The first corresponds to Onora O'Neill, who has pointed out that it is incoherent to propose a human right to health because to every right there must be a correspondent duty and in this case, it is not possible allocate *who* should bear the correspondent duties. The second belongs to Gopal Sreenivasan. Although he has presented different arguments to reject the possibility a right to health, here I will discuss only his argument regarding the 'doubly universal' condition for every human right, and how this condition cannot be met by a pretended right to health. After reviewing these objections, I will explain what would be a strategy that relies on a duty to charity for the global promotion of help. I will also argue how this contrast allows us to appreciate the advantages of a human rights narrative.

Onora O'Neill's objection to a human right to health

There are two main arguments that O'Neill poses against the possibility of a human right to health. The first stresses the interdependence between rights and obligations and denounces the incoherence of defending a human right to health that aims to be universally claimable, but that cannot allocate *who* is responsible for the claimed demands. The second argument focuses on the distinction between liberty and welfare rights to claim that a right to health is properly

a welfare right and that as such, it cannot be regarded as a human, pre-institutional right. Together, these two arguments constitute a strong objection to the defendants of a human right to health.

Firstly, I will address the argument about the interdependence between rights and obligations. O'Neill contends that some discourses about human rights have abused a cosmopolitan rhetoric making rights the center of the discussions about justice and leaving behind concerns about the allocation of the correspondent obligations. After all, it is more promotable and certainly easier to propose that some demand must be universally claimable as a human right than stating precisely how—and especially, by *whom*—that demand is supposed to be met. O'Neill says that:

... only if we jettison the entire normativity understanding of rights in favour of a merely aspirational view, can we break the normative link between rights and their counterpart obligations. If we take rights seriously and see them as normative rather than aspirational, we must take obligations seriously. (O'Neill 2016, p. 196)

It would be one thing to defend a human right to health if we only pretend to point out an aspirational or humanitarian goal that would serve as an ideal, without any kind of normative force—but this weak scenario is not what is expected from a human right to health. For example, the ICESCR has made it possible—through the Committee on Economic, Social and Cultural Rights (CESC)—to receive reports from its State parties and to make some suggestions about what they can improve (Gostin 2014, p. 252). Although considered an important step, this has also been regarded as insufficient. The main problem with focusing too much on the rights and leaving behind their counterpart obligations is that even if there is an individual claim to health, there is no one that is accountable for meeting that demand—and after all, 'rights are *demands on others*' (O'Neill 2000, p. 126). From O'Neill's reading, it is incoherent to think about a human right to health if we cannot offer an account of who is responsible for what is being claimed. But this question about *who* is responsible in the specific case of a human right to health is what leads us to the second part of O'Neill's objection: the distinction between liberty and welfare rights.

Liberty rights have also been named 'civil and political rights' (Gostin 2014, p. 246) and 'negative rights' (Nagel 2005, p. 127), because they only demand that others do not interfere with these rights. It has also been assumed that these liberty rights, precisely because they are negative rights, demand "no positive action or resource commitments from government." (Gostin 2014, p. 246) In contrast, welfare rights have been considered a kind of 'positive right', because they demand more than just a non-interference policy from States and from

the international community. Welfare rights are also identified as ‘economic, social and cultural rights’ and, unlike liberty rights, it has been assumed that they imply a much bigger commitment on behalf of the State (both in terms of positive action and resources) in order to meet the claims of welfare rights.

The idea that one of the most striking differences between liberty and welfare rights is the level of commitment that is being asked from the States has been widely criticized. If we think of this contrast in terms of individual liberties and socioeconomic rights to public goods, this certainly can lead us towards this conclusion—but “the idea that civil and political rights impose no affirmative State obligations, while socioeconomic rights impose costs on societies, is vastly oversimplified.”¹

Departing from this explanation of the difference between liberty and welfare rights in terms of positive or negative rights, and of the commitment assumed by the States, O’Neill explains the difference between liberty and welfare rights² in terms of a right’s universality and its independence from any given institution. Liberty rights have a universal scope, regarding both their right-holders and their duty bearers. That is, any human being has a right to freedom of speech or to freedom of religion. Equally, every human being has the duty to respect these rights of others, and States must assure that this condition is met. Liberty rights assume the whole international community both as the right-holder and the duty-bearer. Welfare rights, however, cannot have this universal scope. Even if we consider that every human being has the right to health, its correspondent duty cannot also rely on the whole international community. Providing health care, or preventive care such as vaccinations, is not a task that can be

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1 For more detail on how this has been used as an argument against the possibility of welfare rights (and especially against a human right to health), see: John Tasioulas and Effy Vayena (2015a). They argue that there is not an antagonistic relation between these rights, and that both liberty and welfare rights, require an important commitment in resources and in positive action by the government.

2 This distinction has also been explained as a contrast between individual and collective rights. The existence of collective rights has been widely discussed (Spicker 2001, p. 9). Even if O’Neill does not appeal to the distinction between individual and collective rights to explain liberty and welfare rights, I consider that this is also an important distinction because both pairs of rights have been regarded as equivalent—liberty rights being individual rights, while welfare rights are collective rights. If we accept that for something to count as a right it must be individually claimable, this equivalency would prove to be detrimental to the defense of welfare rights and thus, to a human right to health. This has raised arguments that there are no collective rights and that there cannot be individual claims to collective public goods such as health or food. Thus, this individualist feature of human rights has been important to distinguish what can count as a human right and what should be excluded. For more detail, see: John Tasioulas and Effy Vayena (2015a; 2015b).

done by every individual around the world. For conditions of health to be met it is necessary to appeal to certain institutions—in this case, States as primary agents of justice and other institutions like hospitals or clinics, as secondary agents of justice.³

For O'Neill, the right to health cannot be regarded a human right because it does not have a universal scope regarding the duty bearers; that is, we cannot allocate its correspondent duties to the international community even if we want to ascribe the claimable individual right to every human being. Moreover, it cannot be a human right because it necessarily relies on the existence of certain institutions. Its alleged universality as a human right cannot in fact be independent from institutional structures, and for this reason, O'Neill concludes that welfare rights, such as the right to health "must be special, institutional rights rather than universal human rights." (O'Neill 2016, p. 199)

O'Neill's objection does not stop there. The first part of her objection affirmed that it is incoherent to normatively sustain human rights without allocating the duties implied in them. But from what I have said here, it would appear that this challenge can be dismissed because O'Neill recognizes the States as primary agents of justice and other institutions (from hospitals to NGOs) as secondary agents of justice. At least, this is the standard position when thinking of who is responsible for guaranteeing and protecting human rights, and this is how it is managed by the ICESCR and its State parties. But O'Neill not only considers that welfare right are institutional and not human rights—she also strongly criticizes this standard position for both human and welfare rights, and discusses the great difficulties of allocating the duties of welfare rights.

If a right to health is institutional given its dependency on being fulfilled only by certain given institutions, then the success of this kind of rights depends on the reliability of its institutions. But O'Neill, challenging the standard view, affirms that States are ill suited to being primary agents of justice for welfare rights. The same cosmopolitan rhetoric denounced by O'Neill for focusing too much on defending rights and too little on allocating duties is also responsible for idealizing States' agency regarding the institutional right to health. She dis-

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³ The distinction between primary and secondary agents of justice is used by O'Neill to identify who has the greater responsibility regarding the realization of rights. Simon Caney explains O'Neill's distinction, saying that while primary agents of justice have a legislative and an executive role, secondary agents limit themselves to the tasks assigned to them by the primary agents of justice. Caney further claims that this distinction is very important to thinking of how human right's correspondent duties can be allocated, but he claims that we could understand this difference as two compatible roles that can be adopted by different institutions, rather than different kinds of agents (Caney 2013, pp. 133–156).

tinguishes between an abstract and an idealized theory: abstraction, on the one hand, is indispensable, because only by leaving some act-descriptions indeterminate can we offer a proposal that is suitable for a plurality of diverse agents; idealization, on the other hand, does not leave indeterminate certain predicates and rather, it erroneously asserts or denies some predicates about the agents involved (O'Neill 2000, p. 68).

The standard view regarding the States' role as primary agents of justice for welfare rights is guilty of idealizing States' agency. O'Neill thinks that every idealization leads us to a 'rosy view' in which individual rights are guaranteed by the State, and reminds us that:

... we do not inhabit an ideal world. Idealized conceptions of justice simply do not apply to international relations, social relations or individual acts in a world in which states, men and women always lack the capacities and the opportunities of idealized agents. (O'Neill 2000, p. 162)

One way to avoid this idealization is to recognize that States are ill suited for being the primary agents of justice for welfare rights, because they lack either the capacities or the resources (or even both) needed to accomplish this. O'Neill identifies three possibilities that not only aren't farfetched, but are rather common, and that could severely undercut the efforts towards realizing an institutional right to health. States can be: (1) unjust with their own people, such as tyrannies and rogue States; (2) incapable of securing justice for their citizens because they either lack the capabilities to enforce their law successfully or because they lack the minimal infrastructure needed to secure welfare rights, such as schools or hospitals; or (3) weakened by different processes of globalization that give international agencies more power within their boundaries (O'Neill 2016, pp.164–165).

In light of these difficulties, O'Neill suggests that we cannot continue with our idealized conception of States' agencies, but nor can we wait until all these problems are solved to continue the realization of institutional or human rights. To wait until States can be sufficient primary agents of justice would amount to returning to an aspirational or humanitarian conception of rights, disregarding their normative role.

Instead of abandoning their normative role, O'Neill invites us to consider the possibility of replacing States in their role as primary agents, and to be more flexible regarding who can be responsible for the duties entailed in institutional and human rights. She argues that for the realization of an institutional right to health, it is indispensable to recognize the importance of globalization and how it has shaped the way we think about epidemics, contagious diseases,

the availability of vaccinations and health services around the globe. For example, some NGOs have been able to substitute for or substantially aid different States in providing all the services that a right to health implies. O'Neill asks us to consider more global agents to whom we could allocate the correspondent duties of a right to health. This strategy has the advantage of not relying on an idealized conception of States' agency, and because it is not territorially bounded, it can better address global health problems.

Gopal Sreenivasan's objection to a human right to health

Gopal Sreenivasan has given several arguments to refute the possibility of a right to health.⁴ In this section, I will only explain why Sreenivasan thinks that there cannot be a *human* right to health. Although he does not deny the existence of a State's duty to take care of the conditions for its citizen's health, he denies that we can find a correspondent right to this duty. For Sreenivasan (as well as for O'Neill⁵), the relation between rights and duties can be explained in the following way: for every right, there must always be a correspondent duty and a duty

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⁴ Sreenivasan has been a strong and extensive critic of a pretended right to health. I consider it important to briefly say here why he considers that any right to health is unattainable. One of Sreenivasan's most devastating arguments against the possibility of a right to health is to appeal to the 'nature of health'. This argument claims that health is an outcome that depends on many factors, among them, luck and biology. From this, he affirms that there cannot be any duty that can be held against the State to assure that all the relevant factors of health are met. Given that there can be no rights if there is no allocation of the proper duties, a right to health cannot be understood as an outcome. He also considers the arguments that try to replace 'health' for 'health care' in the formulation of this human right to dismiss the 'nature of health' argument, and to claim that what is being demanded is not an outcome but a service. He discredits this too, by pointing out that health care is just one part of what a right to health pretends to claim, so that it would be a morally defeating strategy to falsely equate health to health care. These arguments are very important to understand Sreenivasan's position, but I have decided to focus just on his argument against the possibility of a human right to health, and not against a right to health in general, because I consider that it emphasizes an important difficulty entailed by a common conception of what it takes for something to be regarded as a human right. See: Sreenivasan (2012; 2016).

⁵ "While claim rights are mirror images of obligations, not all obligations have mirror images (...) This thought by itself is reason enough to *begin* with obligations and not with rights." (O'Neill 2000, p. 99)

bearer, even if not every duty entails a right. Sreenivasan explains this thought with the following example. Even if one accepts that:

... there is a moral duty to provide—or even, that some agent has a moral duty to provide—individuals in a given population with herd immunity against contagious disease (...) [one can still deny] that any individual has a moral claim-right that correlates with any agent's moral duty to provide herd immunity. (Sreenivasan 2016, pp. 347–348)

He assumes that the agent who could bear this duty is the ‘domestic state’ (Sreenivasan 2016, p. 360), but even with this consideration, he rejects that from this duty we could conclude the existence of a right to health.

First of all, he takes human rights to be a special kind of moral rights rather than international legal rights. Then, he asks what distinguishes human rights from other kinds of moral rights, and what makes them “more than a random label for any old universal standard of justice.” (Sreenivasan 2016, p. 360) The answer is what he calls the ‘doubly universal’ (Sreenivasan 2016, p. 355) condition of every moral *human* right. As the name suggests, it alludes to two universality requirements that must be met by a moral right in order for it to be considered a *human* right.

The first universality requirement is called the ‘synchronic universality’ and it demands that “if any human being has a given human right, then every other contemporary human being also has that right.” (Sreenivasan 2016, p. 355) This entails that every human being on earth has the same claim-right to health. Even if we overlook the difficulty (outlined by O’Neill) of the allocation of the correspondent duties, there is another problem when we consider whether a right to health can meet this first universality requirement. That any human being on earth can claim her or his right to health regardless of the correspondent State’s resources would be an idealization, if not a serious mistake. One cannot claim a right to health without considering the specific socioeconomic conditions that shape one’s access to health care, vaccinations, clean water or food. From this, it seems problematic to assert that a right to health could meet the synchronic universality requirement, because even if we want to assert that every human being has a right to health, actual economic conditions will determine whether each one of them actually has the possibility of claiming and receiving what is guarded by this right.

This consideration leads us to what Sreenivasan identifies as the ‘moral substance’ universality requirement, which he explains through the slogan: “One world, one standard.” (Sreenivasan 2016, p. 355) This second requirement affirms that “for any particular human right that all contemporary human beings have, the moral substance conveyed by the right is the same for every right-holder.”

(Sreenivasan 2016, p. 355) The difference between the first and second universality requirement is that this last one adds a temporal criterion on how a *human* right should be realized. For Sreenivasan, moral *human* rights should always rule out “the doctrine of ‘progressive realisation.’” (Sreenivasan 2016, p. 355) The realization of a moral *human* right to freedom of speech is not a goal that must be gradually achieved. Rather, it is a moral rule that states how we should act towards others’ rights and what we could individually claim as our right to do. But this is not the case with a human right to health. It is impossible for it to be realized at once. Rather, it would seem that what we consider to be the defining characteristics of a human right to health, such as access to some services and goods, is inherently relative to a plan of progressive realization, depending on the limited resources and capacities that any State (as duty bearer) would have. As an example, Sreenivasan says “the state of Senegal simply cannot afford to spend \$1038 (PPP) annually per capita on health.” (Sreenivasan 2016, p. 360) If we concluded that the State of Senegal cannot realize the human right to health as other States are doing it during the same period, would this be enough to blame the State of Senegal for the failing of the human right to health? Could we hold accountable all those States that, due to their limited resources, fall behind on the ‘moral substance’ universality requirement?

The most fundamental idea to Sreenivasan’s second universality requirement seems to be that human rights should exclude the possibility of different States implementing the same “right at different levels or to different standards without infringing on their correlative moral duties.” (Sreenivasan 2016, p. 355) As stated by the ICESCR, a human right to health entails that every human being has the right to “the enjoyment of the highest attainable standard of physical and mental health.” (United Nations, Treaty Series, vol. 993, art. 12) The kind of health care that one can receive and claim varies greatly from country to country. It would seem that ‘the highest attainable standard of physical and mental health’ can only be determined within each State’s boundaries. If this is true, there can be no universally claimable human right to health, because the duties that correspond to this claim are dependent on the limited resources and capacities of the State as the morally responsible duty bearer.

Moreover, we can conclude that States with the most limited resources are not the only ones that cause this failure to meet the second universality requirement. Even in those countries that can guarantee access to health care to all its citizens, and that regulate access to clean water, food and preventive goods such as vaccinations, there is always room for improvement. Unlike other human rights like the right to freedom of expression, a human right to health can be pro-

moted more fittingly, according to the needs of the people, by better infrastructure, resources and education.

The difficulty arising from the second universality requirement has led to the consideration of welfare rights as secondary rights, and this is reflected by international agreements:

Scholars sometimes frame civil and political rights as “first generation” and economic, social, and cultural rights as “second generation”. Despite the unity and equal status of human rights in the UDHR, international treaties reflect this divide. The ICCPR demands immediate state compliance, while the ICESCR is progressively realizable. The collective nature of socioeconomic rights, the progressive realization, and connection to resources meant that they would not be as rigorously enforced. The second generation of rights —although of equal value— has in practice been relegated to secondary status. (Gostin 2014, p. 246)

Unlike human rights that can be enforced right away (for example, to prevent the obstruction of liberty rights), a right to health can only be achieved progressively. The ICESCR recognizes this in its second article by stating that:

Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures. (United Nations, Treaty Series, vol. 993, art. 2)

This article leads us to accept what Sreenivasan denounces—that is, that a right to health cannot meet the second universality requirement: “‘One world, one standard’ turns out to be a rather challenging requirement for a right to health to satisfy.” (Sreenivasan 2016, p. 361) If human rights are characterized by virtue of their doubly universal nature, and a right to health cannot satisfy these requirements, it follows that, just as O’Neill also concluded, a pretended right to health cannot be regarded as a human right. Furthermore, even when O’Neill accepts that it can be an institutional right, she points out severe difficulties entailed in its realization. In the same way, Sreenivasan’s criticisms lead us to question whether it is a worthy strategy to keep trying to defend the existence of a right to health, even when it would not be considered as a human right. Along the lines of both authors’ arguments, we could ask now whether it would be better to just consider a certain duty towards health, that States should bear, even if this does not have a correlate claim-right. What would that duty be?

Taking global health seriously: the insufficiency of a duty to charity

O'Neill's and Sreenivasan's arguments have pointed out the difficulties of realizing a right to health even within a State's boundaries. As long as this right depends on institutional structures and these are insufficient, the realization of this right will be at risk. When we consider these difficulties from a global point of view, the problem seems to amplify. If a State cannot successfully bear its duty towards its own citizens, what kind of duty could be enforced between different States to promote health globally?

If we decide to abandon the human rights narrative, and even the defense of an institutional right to health, it would still be possible to say that every State bears a duty to its own citizens to provide conditions for their health.⁶ But here I want to suggest that the strategy of considering States' duties is also insufficient for promoting health conditions for every human being.

The question about what kind of States' duties could promote health globally has raised a debate between cosmopolitans and communitarists about the existence of international duties to justice and, in this case, of international duties to promote health. I will not discuss this debate here. Instead, I want to point out how unsatisfactory it is to establish a duty to charity as an international strategy to promote health.

One of the main problems regarding international relations of justice is that it recognizes each State's sovereignty as fundamental, up to the point that it does not necessarily entail any enforceable duties towards other States—or even towards human beings that are not citizens, even if they are within that State's boundaries. One strategy to avoid the problems corresponding to international duties of justice has been to appeal to a duty to charity between States. This strategy has had important outcomes, and has been more easily adopted because a duty to charity is less demanding for States than the recognition of an enforceable human right to health. This duty to charity only supposes that: "one can help others in serious distress without excessive cost to oneself." (Nagel 2008, p. 52) It does not impose how many resources should be invested towards pro-

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⁶ I do not intend to address here the degree up to which a State should care and provide for the conditions of health of its citizens; nor whether this would have to involve every State providing universal access to health care, or even to vaccinations and clean water and food. I consider simply that all States should bear this duty, even if we accept that there could be varying degrees of each State's level of commitment.

moting global health—rather, it can be left up to each State to decide how to manage their aid towards other countries.

Although this duty to charity has been carried out with fewer problems than the strong enforcement of an alleged human right to health, it faces serious objections when regarded as a solution or as a way to promote global health. Two strong criticisms of the duty to charity as a replacement of the human rights strategy are: firstly, that a duty to charity always entails a dubious distinction of who is most in need and thus most deserving the correspondent aid, creating more inequality; and secondly, that charity neither remedies nor corrects the underlying structures from which many health problems arise at an international level—it merely reaffirms the dependence of some States on others.

A duty to charity is flawed from its very conception as a viable way to promote global health. Firstly, it could be argued that all foreign aid should be directed towards helping those most in need. This leads to the distinction between the ‘very poor’ and the ‘relatively poor’ (Millum 2012, p. 27), which creates more inequality: the international community can leave behind those who are not most in need—even when they face severe health problems—because their aid is not (yet) intended for them. But how can it be decided who is most in need? And *who* decides where the aid should go? This undetermined structure of charity has promoted that biased political and economic interests become the factors that decide who receives help now, and who should wait until their situation worsens to receive it.

The second problem with charity is that even when regarded as a duty, it necessarily entails a relation between unequal partners—one in desperate need and one with enough resources to help others without compromising its own interests. If we rely on this structure to promote global health, there can be no real progress; just momentary relief for those in the most vulnerable positions, but without an actual solution. The point of these criticisms is not that a duty to charity is useless. Instead, it emphasizes that it is not an actual solution because it does not challenge the causes that obstruct the realization of the conditions for health.

Every action that can be regarded as charity assumes from the start a parallel between inequality of wealth and inequality of power (Nagel 2008, p. 52). From this starting point, global health does not stand a chance, because the resources needed to promote it are still being withheld from those in need. Furthermore, weak States could argue that they are not able to perform their duties towards their citizens due to lack of donations, and given that aid is not mandatory and it is not a reliable source of resources, this attitude could lead to a worsening of the conditions of health for citizens of these countries (Gostin 2014, p. 19).

Appeals to charity, even when regarded as a special international duty, may still seem a more feasible way to promote global health than posing a human right to health, which faces the criticisms presented earlier. But in fact, a duty to charity would not accomplish much towards this global goal, because:

Rich donors remain rich (...) the poor remain poor, though, for the moment, not in desperate need. Humanitarian aid is essentially conservative; it preserves existing power structures (...) By contrast recognizing someone's rights is (...) to put them in control (...) It is to accept another person's legitimate claims to power. Rights claims are not restricted to needs, but also extend to liberties and opportunities (...) Humanitarianism is, therefore, attractive to those who are in power and like to keep things that way. (Wolff 2012a, p. 8)

If we take seriously the thought of global health, it seems that there are important reasons to recover the human rights narrative, even with all its problems. Here, I will present what I consider to be three of the most relevant reasons to continue with the human rights narrative.

First, one weighty flaw of a duty to charity is that it disentangles global health from a correspondent sense of responsibility. From the point of view of charity, wealthier States do not have an obligation to make donations or provide aid to others, and weak States may excuse themselves and disregard their responsibilities towards their citizens just by maintaining that they have not received enough resources. In this scenario where no one is responsible, charity leaves us with a far more diminished hope of achieving global health. A human rights narrative, although having the problem of allocating specific duties, recognizes the need of asking who would be responsible for achieving those rights.

Second, if we consider global health to be 'a globally shared responsibility' (Golin 2014, p. 19), we must make explicit the damaging effect of international omissions. A duty to charity cannot address the lack or insufficiency of donations as a morally worrisome omission, precisely because it does not recognize any inherent responsibility for donors. The human rights narrative, by contrast, makes visible the impact of omissions:

Individuals may have been wronged through neglect, but no rights would have been violated, on such a view. However, once the claim is made that rights will be violated if assistance is not forthcoming, the argument has shifted to one of justice: that we neglect or violate people's rights by failing to help. (Wolff 2012b, p.79)

Unlike a duty to charity, an appeal to human rights can point out the need to find agents that are responsible for global health. It can also help to denounce what is *not* being done to promote it, and to emphasize the need to repair this failure.

A third advantage of the human rights narrative is that it does not presuppose a hierarchic structure in which what motivates global health is not a human entitlement but, on one hand a never ending need and, on the other, mere philanthropic donations. Given that charity has as its core the idea of need as its motive, it cannot end it; charity's aim is just to briefly mitigate it.

These three reasons offer an important counterweight to criticisms of human rights and of the possibility of a human right to health. One of the most relevant flaws of a human right to health, as regarded by O'Neill and Sreenivasan, is that it does not meet certain universality requirements that are usually considered to be the defining features of any human right that can be legitimately regarded as such. But these criticisms do not necessarily force us to abandon this narrative. Instead, they can be seen as good motives to revise what we consider fundamental about human rights and, perhaps, to reconsider how have we been thinking about their universality.

Concluding remarks

One way in which globalization has shaped theoretical discussions about health is that it has shown how flexible and limited boundaries are, when we consider health problems and the resources and capabilities we have to address them. The multitudinous factors that are relevant to people's health around the globe cannot be bounded within States. Certain "situations can only really make sense from a global perspective that takes in the structure that affect people's lives (...) And it is only from a global perspective that options for addressing their difficulties can be identified." (Millum 2012, p. 2)

This change of perspective, which is necessary to address contemporary problems of health, has not yet found an appropriate theoretical justification. One way it has been defended is by posing a human right to health. But this idea has received strong objections that question whether it is actually possible to claim a *human* right to health, and whether this would be the best strategy to promote health. In this essay, I have intended to show that although it is not free from difficulties, it still is the best strategy available in order to continue to defend a global perspective on health. Much still needs to be said about how a right to health can be considered a human right if it does not possess the universal requirements that we have ascribed to other human rights since their inception. I consider that these objections raise an important challenge to the way we think not only about global health, but about human rights in general. Perhaps, in adopting this global perspective, we could reconsider the way we think about

the relationship between universal requirements and global demands regarding health.

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