

Health Justice, Equality and Fairness: Perspectives from Health Policy and Human Rights Law

One has the strange impression of switching between parallel worlds when reading the main human rights and health policy works on the issues of health justice. Different contexts, intellectual traditions, conceptual frameworks and arguments, while running their own course, seem to be driven by similar fundamental concerns about what it is that a society ought to do regarding people's health needs. Instead of crossing over from one discourse to the other, it is desirable to have the two "talk" to each other.

ERT spoke with Norman Daniels, Professor of Ethics and Population Health at the Department of Global Health and Population, Harvard School of Public Health, Harvard University, and Paul Hunt, Professor at the Department of Law/Human Rights Centre, University of Essex, and former United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (August 2002-July 2008). We spoke with Professor Daniels on the phone, and recorded and transcribed his replies. Professor Paul Hunt provided us with his written answers to a few related questions. Each has seen the replies of the other, although they have not had the chance for a real live dialogue. But each word below is their own, and each question is presented exactly as asked. Still, this notional double interview is a "fabrication" which, while it cannot create a dialogue between international human rights lawyers and health policy experts, can at least demonstrate the need.

ERT: Professor Daniels, you are one of the leading authorities on health justice and health equity. How did you become interested in this area?



Norman Daniels: Through my initial interest in my own work in political philosophy, I became interested in examining theories of justice to see which had the best support. It seemed to me at the time that there was more agreement about how to distribute health-care than a number of other social goods, so it gave better answers about how we should carry out such distribution. I later came to see that this was a bit naïve, but nevertheless, that was what initially got me thinking about justice and healthcare. So my route to this area of interest was through more theoretical concerns. My interest in health and healthcare has subsequently grown as a separate focus of interest.

ERT: Professor Hunt, you are one of the leading experts on the right to the highest attainable standard of health (or "the

right to health" for short). Can you tell us what led you to become involved in this area and why you consider it to be an important area of research and action?



Paul Hunt: For some years I focussed on classic civil and political rights, but, in the early 1990s, I shifted my attention to economic, social and cultural rights. At that time economic, social and cultural rights were grossly neglected by virtually everyone – the UN, courts, national human rights institutions, established human rights non-governmental organisations, and so on. As for professionals working in the domains of economic, social and cultural rights - health workers, educationalists, or nutritionists - for the most part they had not even heard of the rights to health, education or food. And how could they? Almost nobody was talking about them! Yet economic, social and cultural rights are a central feature of the international code of human rights, as well as numerous national constitutions. It seemed to me that it was wrong for the human rights community to privilege civil and political

rights and neglect economic, social and cultural rights. Of course it was no coincidence that these much-neglected economic, social and cultural rights were especially important to much-neglected communities, especially the disadvantaged and impoverished. The first economic, social and cultural right that I wrote about was the right to the highest attainable standard of health, because its implementation is a matter of (literally) life and preventable death for billions around the world.

ERT: Given that your mandate as UN Special Rapporteur was extensive and complex and your resources extremely limited, how did you organise your work?

Paul Hunt: Before identifying my objectives as Rapporteur, I consulted widely and finally settled on three main goals. One, to raise the profile of the right to health as a fundamental human right; two, to clarify the legal obligations arising from the right to health; and three, to search for ways to operationalise this fundamental human right. Additionally, I decided to focus on two themes: poverty and the right to health; and discrimination and inequality and the right to health. Over six years, these goals and twin themes shaped my thirty-or-so UN reports. They reflect what I saw as the main challenges in 2002 – and these remain pretty much the main challenges today.

I wrote right-to-health reports on the countries I visited, prepared thematic right-to-health reports, such as on maternal mortality, and took up with governments numerous complaints I received from ordinary people alleging that their right to health had been violated¹.

ERT: In your reports, how did you address the issues of fairness, equality and equity in health?

Paul Hunt: My twin themes of poverty and non-discrimination were designed to ensure that the issues of fairness, equality and equity were always central to my work.

These issues led to particular thematic reports, such as the UN General Assembly report on mental disability and the UN Commission on Human Rights report on sexual and reproductive health. They also led to particular country reports, such as the report on neglected diseases in Uganda - neglected diseases are those mainly suffered by the poorest people in the poorest countries. Fairness, equality and equity also led to reports on undocumented people in Sweden and indigenous peoples in Peru. Of course, when I wrote on other issues, such as access to medicines, I looked at fairness, equality and equity because they are key elements of the right to the highest attainable standard of health. In 2008, I submitted to the UN General Assembly *Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines* that include provisions on disadvantaged individuals, communities and populations; these provisions are explicitly based on the human rights concepts of equality and non-discrimination. The following year, I applied these concepts to the specific policies and programmes of GlaxoSmithKline when examining the right-to-health responsibilities of this major pharmaceutical company.

My reports remind states, and others, that they have a legal obligation to provide access to health-related services without discrimination and this means that they must have in place out-reach programmes for disadvan-

tagged individuals and communities that are sensitive to, for example, gender and cultural context.

ERT: When promoting fairness, equality and equity, what were among the main obstacles you encountered?

Paul Hunt: Many governments do not have in place effective health information systems enabling them to know the health status of individuals and populations in their jurisdictions. In many cases, the absence of reliable health information extends throughout the country, including to the dominant population groups. But the data problem is even more acute in relation to disadvantaged populations, such as ethnic minorities, indigenous peoples, the rural and urban poor, migrant workers and so on. Even if available, very often, the data are not routinely and reliably disaggregated by sex, ethnicity, rural/urban, age, socio-economic group and so forth. Of course, this makes it difficult to formulate and implement the most effective health policies, programmes and projects that will reach these disadvantaged groups.

Despite these data limitations, much more could be done, in all the countries that I looked at, to put in place health-related out-reach programmes for the disadvantaged and impoverished. Of course, better health information would help to make these programmes sharper and more effective. But most governments have enough information to establish more effective out-reach programmes than they presently have in place.

Also, although governments have legally binding obligations to enhance access to health-related services for all, rarely are these obligations either considered in the relevant policy-making processes or argued

before the courts and other adjudicative mechanisms.

ERT: Professor Daniels, what do you consider to be the main challenges to equality and fairness in healthcare, in the United States and internationally?

Norman Daniels: The United States is, in my view, a somewhat different problem to that in many other OECD countries, as well as some of the middle and low-income countries. In the United States, we have less commitment to distributing healthcare more equally than we do other goods. In most European and Commonwealth countries, there are long-standing forms of systems that deliver universal coverage to their populations. In the United States, however, this has been a big issue. Just recently, on 19th January 2011, there was a vote by the Republicans, who have regained control of the House of Representatives, through which they tried to repeal the Obama health reform, which had partially closed the insurance gap but did not even do that universally. In general, in the United States, we have strong vested interests that are more concerned about making money out of healthcare than they are about equity in healthcare, and those interests stand in opposition to universal coverage in the United States. The politicisation of this issue in a partisan way is a great misfortune, but it really does reflect a longstanding disagreement between the conservatives, the liberals and the centre in the United States. There ought to be a state role in delivering healthcare to the population. So in the United States, I see this as an ongoing and rather serious problem.

In many other wealthy countries, I think there are in place better efforts at health systems, which are more equitable in the dis-

tribution of healthcare. In the last 30 years, we have learnt from social epidemiology that the distribution of health in a population is not simply the result of the distribution of healthcare. There are significant health inequalities in all countries, whether or not they have universal coverage. For example, the distribution of education, jobs, residential housing, and political opportunity, including political participation, can all have a significant impact on the distribution of health in a population. So the health inequalities that exist in many wealthy countries reflect some of those inequalities, despite there being a system of universal health coverage. I think there remain a lot of problems in other countries. But in many of them where there is at least universal health coverage for medical services, there is some growing awareness of the other relevant factors which I have identified, which means there may be efforts to make policies more equitable regarding health.

ERT: Is there a country at present that is the best in terms of healthcare fairness? How do you assess the other wealthy countries, especially in Western Europe, as well as Australia, Canada, New Zealand? Do you have a favourite?

Norman Daniels: No I don't have one favourite country. There are different efforts in different countries. There are several countries that take reasonably good approaches. For example, Norwegian and Swedish efforts impress me. There is also a lot of concern in the UK about equitable distribution of healthcare and the result is better there than elsewhere. There are several countries which I think do a reasonably good job at promoting equality in health.

ERT: You have in the past been recognised for your conception of healthcare justice based on fair equality of opportunity. As the concept of fair equality of opportunity has no universally agreed definition, could you explain how, if at all, this principle should be translated into making rationing decisions in healthcare? What does it mean to make a choice in healthcare rationing such that the choice advances fair equality of opportunity?

Norman Daniels: I must firstly question the assumption behind your question. It is true that I do indeed argue that a general principle of protecting opportunity and, perhaps, the Rawlsian principle of fair equality of opportunity is an appropriate one, and such a general principle gives you a general picture of the grounds for our obligation to protect health in a population. I am very clear, however, that I do not think that this principle can answer a whole range of important resource-allocation and rationing questions. For that reason, I have argued that one has to supplement this principled account of fair equality of opportunity with a fair deliberative process. There is reasonable disagreement about how to promote equality of opportunity through healthcare provision in a population, so one needs to have a mechanism for resolving those disagreements. In my earlier book, *Just Health Care*,² I did believe that the equal opportunity principle could answer a lot of rationing questions, but I no longer believe that and argued against that over the last decade.³

ERT: In view of the fact that you do not consider that the principle of fair equality of opportunity can provide sufficient guidance in rationing decisions, do you believe it is possible and indeed desirable to find a set of substantive princi-

ples according to which such decisions can be made?

Norman Daniels: I am not sure it is possible to agree on something that would look like a set of principles, because although there are considerations that we can take to be very important in making resource allocation decisions – such as, for example, the seriousness of the condition, and the amount of benefit we can do through intervention, such considerations interact and trade-off against each other in complicated ways. People reasonably disagree about how to trade such considerations off against each other, so although I think it would be nice to be able to develop a set of principles, I do not think that we are in a position to do that. I think that what we need is a lot more practice at making decisions about more specific types of trade-offs in specific contexts. Maybe out of that we can accumulate commitments as to how to trade these principles off against each other, which could form a basis for further rationing decisions over time. This could emerge as our commitment to a fair system of rationing, but I do not think we are in a position ahead of time to agree on how to do that. That is why we need to focus on achieving a fair deliberative process.

ERT: Turning to your advocacy of a fair deliberative process, how can we be sure that we do not reproduce and entrench the power relationships in society in such a process of deliberation? How can a deliberative process transcend the basic structures of domination and power in society? Does deliberation not legitimise the status quo rather than transcending an unequal and unjust society?

Norman Daniels: I do not think that there can be any guarantees that any kind of deliberative process will transcend power rela-

tions in society. Any straightforwardly democratic process could reflect those relations. Such a deliberation will always risk being biased. But what's the alternative? A group of experts sitting and making these decisions by themselves, without the constraints that come from hearing a range of stakeholders from within society? We all know that those experts themselves may reflect some of the same power relationships within that society. The question is whether this is a reasonable, if not fool-proof, way of arriving at some way of enhancing legitimacy and arriving at fairness. I think it improves on any of the alternatives that might be available to us. There are certainly a lot of questions about how one develops a process and manages it so as to prevent, for example, charismatic people from being able to sway others and thereby hold undue power within the process. It could be that if one had commissions set up that were stacked by the powers that be, then this might serve to replicate the existing power structure in trying to co-opt the deliberative democratic process. There is no procedural guarantee.

On the other hand, we might experiment with different mechanisms to see which of them produces better results. But this raises a hard question: how do you measure what counts as a better result? And how can we gather evidence about which democratic procedures work better? If we knew what counted as a fair outcome, we would not need to find a procedure for arriving at it, unless it was a way to enhance legitimacy, or reassure us that we were coming up with an appropriate solution to a problem where we had agreed upon criteria. It is because we do not agree on the criteria for what counts as a fair outcome of a process, or a fair distribution of resources, that we need a process that everyone can agree is fair. And of course, that presupposes that we can agree on what

counts as a fair process. That is an empirical question and I am not sure how we set about doing that, although we do rely on such procedures all the time, to the extent that there is disagreement.

ERT: Professor Hunt, in your view, given finite budgets, how should a Minister of Health choose between one possible health intervention and another? What does the right to health contribute to the issue of prioritisation?

Paul Hunt: It is sometimes suggested that international human rights law does not permit prioritisation and, some ten or fifteen years ago, that was probably the prevailing orthodoxy. But thinking on economic, social and cultural rights has evolved in recent years. For example, when invited by the UN to prepare guidelines on a human rights approach to poverty reduction, Siddiq Osmani, Manfred Nowak and I came to the more nuanced view that international human rights law permits prioritisation, while imposing certain conditions on the process and outcomes of prioritisation.⁴

Certainly, the right to health remains work-in-progress and one of the areas where much more human rights work is needed is around prioritisation of health interventions. Health economists and ethicists have given a lot of attention to prioritising and rationing health interventions, using principles like cost-effectiveness and equity. Although they have not solved the dilemmas (far from it), they have given the issues considerable attention from which the human rights community must learn. Human rights practitioners have yet to get to grips with these difficult issues, even though prioritisation often privileges the health needs of wealthy, urban populations over the entitlements of the rural poor. In practice, prioritisation often marginalizes

the health entitlements of women, people with disabilities and other disadvantaged groups. This mirroring and deepening of patterns of inclusion and exclusion is offensive to the right to the highest attainable standard of health.

In a UN General Assembly report of 2007, I made some preliminary observations on prioritisation and the right to health. One key point is that human rights sometimes require prioritisation of particular substantive health interventions (e.g. those arising from core obligations), but they also demand a range of procedural considerations (e.g. participation, monitoring and accountability) that must be taken into account when setting priorities. Also, priority-setting must give regard to improving the situation of individuals, communities and populations that are especially disadvantaged, including those living in poverty. Further, while human rights have a constructive contribution to make to prioritisation, they are unlikely to provide neat answers to highly complex issues, any more than do ethics, economics or general theories of justice. Human rights are likely to rule out some processes and some choices, leaving a number of options, all of which are legitimate.

Even though we still await a refined and comprehensive human rights approach to health priority-setting, it is clear, when we look at what is happening on the ground, that most states are not doing anywhere near enough to meet their legally binding obligation to establish health-related out-reach programmes for the disadvantaged and impoverished. And for this, governments must be held accountable.

ERT: Professor Daniels, in international human rights law, there is a recognised right to the highest attainable standard of

health but there is very little dialogue between lawyers, policy-makers and intellectuals in the area of healthcare justice as to what such a right involves. What do you think the right to the highest attainable standard of health consists of? And do you think it is a useful concept?

Norman Daniels: I do think there is a way of talking about a right to health and a right to healthcare that makes sense. First of all, a right to health is not a right that ensures that your health is going to be good regardless of what is done for you. Nobody can guarantee that, and it would be ridiculous to suggest that this is what one means by a right to health. I take a right to health to mean that individuals have a claim to, and society has a correlative duty to ensure, the distribution of the determinants of health in a way that is fair to all people. So one needs some prior notion of social justice in order to clarify what that distribution is.

For example, we all know that there is a socio-economic status (SES) gradient of health. The higher on that SES hierarchy you are, the longer and healthier your life, and that is true in every country. The question, therefore, is which SES differences constitute a fair distribution of the components of SES, for example income, education, or more broadly opportunity. Reasonable people are going to disagree about what counts as fair distribution. How much better off should the best off people be allowed to be? A strict or radical egalitarian approach is a rare bird, and there is no country that is strictly egalitarian in that way. So if one takes that as evidence that nobody really considers this to be a manageable view, then we need to establish which inequalities are acceptable.

Is any inequality that generates a health inequality unjust? If the answer to that ques-

tion is “yes”, then health is the tail that wags the dog of justice and that is problematic, as there are many other social goods besides health which should be taken into consideration. There are many other things that people think are important and that they might, in fact, want to trade health for. We all trade health in our lives for some other kind of goods. We may choose to live far away from our place of work because we like the rural setting, but we may then have to commute longer with the resulting additional risks of death on the highway. Therefore, we all make such trade-offs in our own lives. To suggest that we would never trade health for anything else presents a complication in deciding which other inequalities are allowable if we do not want to let health be the determinant of all of them. If health, however, is just one among many other goods, we need to establish a theory about how to distribute all of such goods. Unfortunately, very few theories give us clear answers to all such questions. So my position is that inequality is an important issue. The question of which inequalities are allowed within a right to health becomes something that we need a more general answer to.

In answer to your question about what I think about the right to health and healthcare, I think of it as implying entitlements that individuals have to a socially relative array of services (in the case of healthcare) that is the outcome of a process of fair deliberation under reasonable resource-constraints. Now historically, the health benefits packages which exist in most health systems are not the result of any such deliberative process. They are historically determined by social practices in medicine and elsewhere. They include many services that are less important than others we might add or substitute for them and since every society faces some level of resource restrictions - as health is

not the only important social good - then reasonable decisions have to be made about which health services are more important to deliver to a population than others. So I see entitlement to healthcare services as a contingent claim that individuals with specific conditions have to services that are part of a reasonable array of services; society decides what that array is through appropriate deliberative procedures. Where we lack those procedures, and we do in most countries, then there is still a body of socially relative decisions that have been made and they may become a background against which one has to make further decisions. But some societies are now in the position where they realise that some process needs to be put in place for making more reasonable decisions about allocation of resources. In the United Kingdom, until the current government came in, the National Institute for Health and Clinical Excellence (NICE) was supposed to help to make recommendations. There are processes in Norway and Sweden for doing that. In Germany, the story is somewhat different. They do not want to impose constraints on anything that counts as efficacious unless there are cost-considerations about the pricing of what is covered. So the mechanism that has been put into place to look at efficiency frontiers for new drugs is an effort to set up price guidelines so the government can negotiate, based on a decision that if something falls below a threshold, then we don't cover it.

In the United States, we are in a much worse situation because nobody wants to address the problem in an honest way. I fear also that something similar is currently taking place in the United Kingdom, given that there was no discussion in the election regarding the decisions now being made in relation to the National Health Service. All of this was a big surprise that was not part of the election campaign and there was no public discussion.

The decisions have been made following the appointment of a new health minister by the new government, and this was not part of a public agenda that has any mandate behind it. It is not transparent in many dimensions and it was never part of any kind of election campaign, although, in my view, inclusion of a discussion in an election campaign does not tell you what the right thing to do is in all cases. This is still to be favoured, however, in a world that respects democratic process.

The current situation in the United Kingdom is a case where something that was not discussed is now being made part of the policy agenda of the government. Whatever criticisms one had of NICE, and I have some, and others have more, it at least was concerned to find out what public attitudes were through its Council and its statements on social values. In my view, it was morally questioning an adherence to a strong cost-effectiveness threshold in light of important arguments that people made that one ought to be flexible about how you use that, and this was a slow ten-year progress. I see that as evidence that there was a deliberative process going on, and people were listening to each other. Now that is going to be buried in the lack of transparency in the new system.

ERT: Professor Hunt, in international human rights law, what are the main elements of the right to the highest attainable standard of health?

Paul Hunt: In 2000, the UN Committee on Economic, Social and Cultural Rights set out in some detail what it understands the right to health to mean. Of course, the Committee emphasises that the "right to health is not to be understood as a right to be healthy".⁵ Briefly, this fundamental human right encompasses medical care, as well as access to safe water, adequate sanitation, a safe working

environment, access to health-related information and education, and other critical pre-conditions of good health. Crucially, it places an obligation on governments to address discrimination and inequality. The right to health requires governments to enhance access for disadvantaged individuals, communities and populations; in other words, it has a social justice component. It also requires governments to put in place arrangements that facilitate the active and informed participation of those affected by health-related policies, programmes and practices. The right to the highest attainable standard of health is subject to progressive realisation, i.e. no government is expected to realise it overnight – or even in ten years – but to progressively work towards its realisation. This means we need indicators and benchmarks to measure whether or not progress is being made. However, the right to health is subject to resource availability, in other words, more is demanded of Canada than Chad. Monitoring and accountability are vital elements of the right to the highest attainable standard of health. Accountability must not be understood to mean only judicial accountability; it also includes non-judicial mechanisms, such as public enquiries established by national human rights institutions, which can be much more accessible to the disadvantaged and impoverished than courts of law. At the core of the right to health is an equitable, integrated, responsive, effective health system that is accessible to all and of good quality.

Plainly, the right to health is extensive and complex. Although subject to progressive realization, some elements of the right (known as “core obligations”) are of immediate effect, such as the requirement of non-discrimination. The challenge is to apply the elements of the right to health - non-discrimination, equality, progressive realization, core obligations, participation, accountabil-

ity, and so on - to specific health issues, like medicines, water and sanitation, sexual and reproductive health, the skills drain, and so on. Addressing this huge challenge remains work-in-progress but, thanks to the efforts of countless individuals and organizations, we are gradually identifying the main right-to-health obligations of states, as well as other actors.

ERT: Professor Daniels, in general terms, how do you envisage the role of human rights lawyers in promoting healthcare justice?

Norman Daniels: I think that it is not the role of lawyers or courts to make specific decisions about coverage. I think what lawyers should be pushing for is to ensure that there is an appropriate process in place elsewhere in the health system, and that the decisions that emerge from it are recognisably the results of that kind of process, with reasons generated as grounds for its policy. I think of the role of human rights lawyers as one of enforcing a fair process in decision-making about healthcare coverage, not in making very specific decisions about coverage themselves.

There is a certain kind of bias within law which is namely that it is largely focused on individuals who have the standing to bring suits, and that raises a question of who is actually identified as a “victim”. The legal process tends to favour somebody who has standing to bring a suit, and might, therefore, have the power and authority to do that as a result, for example, of their wealth. Such individuals with the necessary power and authority stand in opposition to a group of people who might be affected by making resources available to that individual, or individuals like that individual, in favour of others.

I particularly have in mind the mess that exists in Colombia which I see as highly problematic. They have the system of *tutelas* there, through which individual claims based on constitutional rights to life and dignity are brought. These suits focus on healthcare needs that claimants argue threaten life with dignity. The Ministry of Social Protection in Colombia lacks an appropriate form of process for making decisions about coverage. This is a longstanding problem in Colombia as in many other countries. There are often plausible grounds for the courts to say that nobody knows why a particular benefit is part of a benefits package over another benefit, and when it appears to be as important for a life with dignity as something else, there is no reason not to include it. It is unlikely, however, that the courts actually have the resources and adequate information to make such decisions, so I see this as a longstanding dilemma.

Despite Keith Syrett's view in his book on the role of the courts⁶, in which he takes Jim Sabin and I to task having overstated our view on the issue, I think that there is a lot of agreement between his view and mine, which is that the role of the courts in decision-making is to try to make sure that the state puts in place mechanisms for making the decisions in a reasonable way rather than being in the position to decide which particular health programme is more important than another.

One further point I would like to make in relation to the relationship between human rights and priority-setting in health is one which I made in an article which I co-authored with Sophie Gruskin in 2008⁷. Our argument is that there is a very important problem of priority-setting that lurks behind the international framework for human rights. Right claims themselves within that framework do not have priority over each other, and even

claimants to the same right cannot be ranked in order of priority. Therefore, for example, when you undertake an effort to improve a progressive realisation of the right to health in a particular setting, you have many choices which are not determined by priorities that come from within that international legal framework. Our argument was that the approach to priority-setting which Jim Sabin and I were developing might make a contribution in the field of human rights in that it has a lot of points of overlap with it. We are not arguing for a hierarchy of rights, but rather acknowledging that the international human rights framework does not allow us to prioritise. The question is, when decisions such as those regarding what governments should do for the progressive realisation of health are made, why are those decisions made rather than alternatives? This really goes to the problem of legitimacy and the different question of fairness. Such decisions can be unfair to people. Our view is that the human rights approach needs supplementation in order to enhance transparency of the reasons for such choices, and this is an important objective shared by the human rights approach and concerns about justice.

ERT: Professor Hunt, are the health and human rights communities working together to enhance fairness, equality and equity?

Paul Hunt: They have begun to, but there is a long way to go. Both communities could and should be doing much more to reach out to the other. There is no chance of implementing the right to health without the experience and expertise of health professionals, and so the human rights community has to do a much better job listening to and learning from a wide-range of health professionals. This means that human rights advocates have to become familiar with health

concepts and language. For example, some human rights advocates misunderstand the health term 'equity', while some health professionals misunderstand the human rights term 'equality'. In my experience, most health professionals have not yet grasped that legally binding human rights law can help them achieve their professional objectives, including fairness, equality and equity. Regrettably, many health policy makers are

using the right-to-health analysis neither to understand the health realities in their countries, nor to shape robust, sustainable and equitable health policies that are meaningful to the disadvantaged. In other words, a key challenge is for the human rights and health communities to work together more closely, collaboratively and respectfully, with a view to tackling discrimination and delivering equality and equity.

**Interviewers on behalf of ERT:
Dimitrina Petrova and
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¹ For these UN reports, and other publications on the right to health by Paul Hunt, see the Human Rights Centre, University of Essex: http://www.essex.ac.uk/human_rights_centre/research/rth/index.aspx. (Editor's note)

² Daniels, N., *Just Health Care*, Cambridge University Press, 1985. (Editor's note)

³ See Daniels, N. and Sabin, J., "Limits to Health Care: Fair Procedures, Democratic Deliberation, and the Legitimacy Problem for Insurers", *Philosophy and Public Affairs*, October 1997, Vol. 26, Issue 4, pp. 303-350; Daniels, N. and Sabin, J., *Setting Limits Fairly: Can We Learn to Share Medical Resources?*, Oxford, 2002, and 2nd ed. 2008. (Editor's note)

⁴ *Human Rights and Poverty Reduction: A Conceptual Framework*, OHCHR, 2004. See also Guideline 4 in *Principles and Guidelines for a Human Rights Approach to Poverty Reduction Strategies*, OHCHR, 2006.

⁵ General Comment No.14, *The right to the highest attainable standard of health*, E/C.12/2000/4, Para 8.

⁶ Syrett, K. J., *Law, Legitimacy and the Rationing of Healthcare: A Contextual and Comparative Perspective*, Cambridge University Press, 2007. (Editor's note)

⁷ Gruskin, S. and Daniels, N., "Process is the Point: Justice and Human Rights: Priority Setting and Fair Deliberative Process", *American Journal of Public Health*, 2008, 98(9):1573-7; See also Daniels, N., *Just Health: Meeting Health Needs Fairly*, Cambridge University Press, 2008. (Editor's note)