THE RIGHT TO HEALTH: A DUTY FOR WHOM?

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Abstract

The economic, social, and cultural human rights catalogue, including the "right to health," gained increasing importance with the rising popularity of the "rights-based" rhetoric permeating many political and social movements. Rights-based development policy concepts place the respect, protection, and fulfillment of all human rights in the center of the development debate. For many business enterprises, the nature of a human rights obligation that includes affirmative steps to respect, protect, and fulfill human rights in their sphere of influence remains uncharted territory. This induced Novartis to carefully examine and decide on the nature, dimension and limits of its corporate obligations. The following article will outline the current challenges of public health in Africa and the contribution of Novartis in meeting these challenges.

Introduction

No other indicators demonstrate the North-South gap in the physical quality of life as dramatically as health-related ones. There is a fundamental relationship between health deficits and poverty. Poor people who lack education on health matters and have limited or no access to adequate nutrition, safe water, and sanitation also are not likely to have the purchasing power to buy basic health services. There are four broad mechanisms which are responsible for and contribute to the perpetuation of health disparities:

social stratification – the very fact that people are poor;

differential exposure – a greater exposure to multiple health risks (malnourishment, unsafe water, lack of health knowledge, etc.);

differential susceptibility – greater vulnerability due to the interactions among multiple health risks; and

differential consequences of disease – potentially catastrophic income loss, loss of land or livestock, school dropouts, or other illness-produced disadvantages that keep the vicious poverty-illness circle intact.

Corporations are unable and politically unauthorized to address these factors. Yet, they all affect the realization of the *right to health* to which Novartis is committed to contribute. However defined, the *right to health* is interrelated with and interconnected to progress in the realization of all other rights, predominantly "the right to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition of torture, privacy, access to information, and the freedoms of association, assembly and movement. Therefore, Novartis may only be able to make a difference in improving public health in the developing world if it can count on the cooperation of other stakeholders, in particular national and international NGOs as well as federal and local governments in developed and developing countries.

Sustainable progress in the state of health necessitates more than just appropriate health policy and appropriate allocation of resources to a ministry of health. Sustainable health progress depends on and is instrumental for poverty alleviation. Poverty reduction strategies can only be successful if they are followed through by a number of synergistic measures and complementary approaches that respect, protect, and fulfill human rights, including but not limited to the right to health.

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Many of the greatest disparities with fatal consequences are due to preventable conditions and cultural mindsets (social discrimination and prejudices). They result in no or severely impaired access to food, health care, education, and employment. A concerted effort to guarantee the respect, protection, and fulfillment of human rights would not cost a great deal or many additional resources and would save millions of lives.

High-tech solutions such as the most modern pharmaceuticals are rarely needed to combat typical poverty-related diseases. Better nutrition education for mothers (including the motivation to breast-feed), mass vaccination campaigns, access to basic antibiotics, bed nets for malaria prevention, and condom use programs to prevent the spread of HIV/AIDS and other sexually transmitted diseases are inexpensive – the combination of these well-known interventions would have a dramatically positive impact on the health of the poor.

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

2. Bearers of Duties

A meaningful discussion of rights must deal with the respective duty-bearers. Drawing attention to the legitimate sequence of legal duties for the respect, protection, and fulfillment of the right to health is necessary at least for two reasons:

1) by calling to account those who are the first and foremost duty-bearers, to help avoid pushing the debate to side issues, thus giving rise to wrong priorities; and

2) to avoid the development of unrealistic expectations

about sustainable deliverables from the private sector, especially pharmaceutical corporations.

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

2.1. Individual Duties: The state of health of a person and the risks of falling ill are to a great extent determined by individual habits and lifestyles. Individuals must accept their part of responsibility for their own health. Individual commitment and corresponding actions can never be replaced by communities or governments and even less by the international community. Duties in the context of the right to health begin at home.

2.2 Community Obligations: Local communities can do much to improve their members' perception of health risks and to reduce them. Functioning communities regard it as their essential obligation to analyze health-related problems and determine their needs and to initiate community efforts and mobilize community resources that will improve health-related infrastructure. Even poor communities can achieve a great deal, such as encouraging health-promoting behaviors (breast-feeding, use of mosquito nets, cooking of unsafe water) and developing peer pressure against health risks (unsafe sex, excessive alcohol consumption, violation of women's reproductive rights by men of the community).

2.3 State Obligations: States have clear and binding obligations under human rights law. As a matter of fact, all human rights are *above all* incumbent on States and their institutions. States thus do have the prime responsibility to respect, protect and fulfill their people's right to health. This is interpreted to mean the following:

Obligations to respect (e.g. refraining from denying or limiting equal access for all persons to preventive, curative and palliative health services)

Obligations to protect (e.g. ensuring that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability, and quality of health facilities, goods, and services).

Obligations to fulfill (e.g providing adequate health infrastructure and an functioning and socially acceptable insurance system)

Obligation to avoid human rights violations (e.g. outlawing torture, violence against children, and harmful traditional practices).

2.4. Obligations of the International Community: Where the primary duty of the state is neglected – whether due to a lack of resources (incapability) or deficits in governance (unwillingness) – first and foremost the international community ought to be called to account. The international community is expected to take joint action to achieve the full realization of the right to health through development assistance and the right incentive structure.

In the Millennium Declaration, 147 Heads of State and Government "recognize that, in addition to our separate responsibilities to our individual societies, we have a collective responsibility to uphold the principles of human dignity, equality and equity at the global level.

Even before that declaration was made, in December 1986 the General Assembly adopted a resolution with regard to the "Right to Development" and proclaimed among other matters that "States have the duty to co-operate with each other in ensuring development and eliminating obstacles to development. States should realize their rights and fulfill their duties in such a manner as to promote a new international economic order based on sovereign equality, interdependence, mutual interest and co-operation among all States, as well as to encourage the observance and realization of human rights." The practical consequences of the commitments made were less than impressive, however.

Per capita GNP <$760. GNP $761–3,030. [c] GNP $3,031– 9,360. GNP > $9,360.

Source: WHO Commission on Macroeconomics and Health.

Today, only about 10% of official development assistance goes to health issues – equal to just a penny, 1 cent, of every $100 of donor countries' GNP. This is too little to meet even the basic health needs of poor countries.

Donor Assistance on Health, Annual Averages, 1997–99

Income Group	Per Person (dollars)	Total (million dollars)
Least developed countries	2.29	1,473
Low-income countries[a]	0.94	1,666
Lower-middle income countries[b]	0.61	1,300
Upper-middle income countries[c]	1.08	610
High-income countries[d]	—	2
All countries	0.85	5,052

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

2.5 Obligations of The NGO Community: NGOs – in particular, emergency NGOs and religious organizations – rate well in responsiveness and trust among the poor. They have a role in facilitating the voices of poor people and they can be helpful in supporting the formulation and implementation of policies that actually benefit the poor. While NGOs should not be considered as the "silver bullet" for solving all grassroots health problems, they are an important link in the chain. For a sustainable and successful cooperation between NGOs and any other actor – including the private sector – a mutual understanding about respective roles and a perfect "match" is as important as an appropriate climate. Single-issue advocacy pressure groups might not necessarily be among the first partners for cooperation. Whenever pharmaceutical corporations are de-nounced as a greedy, irresponsible, and socially insensitive crowd of "couldn't-care-less" capitalists, it becomes difficult to expect that the same corporations will queue up to commit their funds and technology. What is needed for sustainable solutions is the pooling of resources, skills, and experience and a spirit of "cooperation in good faith."

2.6 The Private Sector

The prime responsibility is to respect, protect, and contribute toward fulfillment of human rights in the context of *normal business activities* and to strive to ensure that a company's activities do not contribute directly or indirectly to the violation of the obligation to respect, protect, and fulfill the right to health. Successful pharmaceutical companies contribute in particular through the results of their research and development endeavors and through resulting innovative ways and means to cure diseases and prevent premature mortality.

3 The Novartis Approach to the Right to Health

Sincere corporate commitments in the context of the right to health – being a positive right whose respect, protection, and fulfillment may require material support beyond what the state is capable or willing to make available – face two important challenges:

There is a structural problem, as private enterprises – being market-oriented and profit-driven – run up against limits in cases of market failure; things turn even worse if market failure and state failure come together and create negative synergies for the poor, leaving them defenselessly exposed to premature death and preventable sickness.

The situation being as it is presents a challenge and an opportunity for moral leadership and corporate vision. The issue at stake is not "doing something or nothing" but "how much," "in what areas," "for whom," "in partnership with what stakeholders over what period of time," and so on.

A sustainable corporate citizenship approach will carefully examine and decide on the nature and dimension of corporate obligations. A suitable distinction can be drawn among:

- essential responsibilities required of any corporation for the respect of the right to health (the "*must*" dimension);
- additional corporate citizenship standards beyond what is legally required, but excluding corporate philanthropy (the "*ought to*" dimension); and

special corporate citizenship endeavors (the "*can*" dimension).

3.1 The "Must" Dimension

With regard to respect for the right to health, as with all other human rights Novartis complies within its own sphere of influence with all laws and regulations concerning healthy workplaces, environmental protection, and the safety of products and services. Moreover, the results of cutting-edge research, development, and manufacturing of high-quality drugs allows for a reduction of premature mortality, the prevention or cure of diseases that are susceptible to drug therapy, a general increase in the quality of life of sick people and cost-reductions through a lower number of hospitalizations.

Under constructive political and social conditions (good governance"), these corporate contributions are of major instrumental value in enabling individuals to lead a healthy life and the state to bear its right-to-health duties.

3.2 The "Ought to" Dimension

Novartis, through implementation of its corporate citizenship philosophy, delivers more than just the essentials. This is particularly important in countries where the legal standards are low or not enforced. Through its corporate citizenship endeavors, Novartis strives to make sure that questionable labor standards and environmental practices are avoided. The company adheres to its self-imposed corporate citizenship norms even if local laws and regulations would allow for lower standards. As a responsible company, Novartis aims to avoid benefiting from unhealthy working conditions or unsafe workplaces of third parties within its sphere of influence and to provide assurances about this as far as possible through declarations on the business practices of customers and suppliers.

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

Some examples of initiatives undertaken by Novartis

1. Projects to de-stigmatize and eventually eliminate leprosy

The UN Special Rapporteur on the Right to Health describes the world's leprosy situation as follows: "Leprosy remains a serious public health problem, essentially (but not exclusively) in the developing countries of Asia and Africa. The disease is closely linked to poverty. Every year 600,000 new cases are diagnosed. Untreated, leprosy causes immense physical suffering and disability, as well as social stigmatization and discrimination born out of ignorance and prejudice. Today [in 2003] it is estimated that tens of millions of people are unfairly and irrationally treated on account of leprosy."

Novartis and its Foundation for Sustainable Development have been actively engaged in the fight against this biblical disease since 1985 and have since 2000 alone contributed to the cure of more than 2.5 million patients by initiating social marketing campaigns to de-stigmatize the disease and by donating the multi-drug therapy to WHO (a practice that will continue until leprosy is eliminated).

2. Projects to improve access to and compliance with tuberculosis treatment

Tuberculosis kills about 2 million people every year – more than any other infectious disease in the world. According to WHO estimates, more than one-third of the world's population is infected with the TB bacillus and about 8.8 million people suffer from TB annually. If left untreated, a person with active TB will infect about 10–15 people every year. HIV co-infection greatly increases the risk of the disease progressing from latent to active TB by weakening the immune system. In fact, TB is the leading cause of death among people who are HIV-positive.

TB can be cured with DOTS – daily observed treatment, short course. DOTS cure patients, prevent the development of drug resistance, and reduce the transmission of TB. However, only 27% of people with infectious TB are treated in DOTS programs. In December 2003, Novartis signed a Memorandum of Understanding with WHO committing itself to donate the WHO gold-standard DOTS treatment for half a million patients over five years. This consists of the rifampicin-based fixed-dose combinations for the intensive and continuation phase of treatment, thereby reducing the duration of treatment from eight to six months. The drugs will be provided in blister packs within patient kits.

3. Projects to support AIDS orphans

The HIV/AIDS pandemic is not only an individual tragedy for the affected and their families; it is also a societal and economic catastrophe. According to UN estimates, the number of AIDS orphans – as a result of 24 million deaths due to HIV/AIDS – is expected to rise from 13.4 million today to 25.3 million in 2010.

In light of this alarming development, the Novartis Foundation supports different initiatives to improve the livelihoods and future prospects of AIDS orphans through individual counseling to help them cope with their situation and capacity building of teachers, social workers, and other caregivers as well as social and economic empowerment (skills development, access to credit, and income-generating activities).

4. An initiative to improve communities' financial access to basic health care services:

Approximately a third of the population in developing countries does not have adequate access to basic health care services. In view of the lack of obligatory health insurance in most developing countries for decades to come, the Novartis Foundation initiated the setting up of a mutual health insurance scheme to improve access for rural populations in Mali. The principle of collective provisions makes it possible to save for health at a time when more resources are available and at the same time to pool the resources of several people. Through this communal provision, the financial costs associated with health risks are "distributed" between community members, with each member paying an insurance premium.

In order to make the mutual health insurance scheme and its services attractive, the project also improves the supply and quality of clinical care. Finally, the project contains a preventive component that should allow households – in conjunction with the insurance scheme – to reduce health care costs and thus those of the scheme itself.

5. A project to understand and improve access to effective malaria treatment

Despite decades of intense fight against malaria, this infectious disease remains a major health burden for developing countries that hinders individual well-being as well as economic development. Some developing countries lose up to 1.3% of GDP annual growth due to malaria.

Together with Tanzanian and Swiss partners, the Foundation aims to identify and analyze the main obstacles to effective malaria treatment and to address them by designing appropriate interventions. Future challenges of this project include motivating people to seek treatment at public health facilities in the event of fever episodes, improving advice and treatment in private drug shops, and improving access for people spending months away from home during cultivation periods.

6. Providing state-of-the-art training facilities for higher health care personnel:

Poor quality of care is a major obstacle to effective diagnosis and treatment as well as to patients' compliance and satisfaction with treatment outcome. Poorly trained and motivated health care staff is at the heart of poor quality of care, as they are the interface between the health care system and the patient.

In order to strengthen human resource development in the health sector in Tanzania, the Novartis Foundation for Sustainable Development and its partners are currently renovating and upgrading an Assistant Medical Officer Training Centre (buildings, training equipment, new specialized staff, and so on). Assistant Medical Officers are a priority cadre for the Ministry of Health as they enhance the quality of essential primary health care services, especially at the district level. Thus an adequate teaching and learning environment will contribute substantially to improved medical expertise, which in turn is needed to improve the overall health situation of the population, especially in rural areas.

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

Given the huge dimension and complexity of the global health problems in the twenty-first century and taking into consideration the tragic human misery associated with premature death and preventable diseases, the right to health debate is expected to gain importance. If one considers "health care" as a right, national governments and international institutions are the primary duty bearers to make all reasonable efforts to respect, protect, and fulfill this right. Responsible governments will start with their commitment by making informed decisions to what extent, given the resources available:

excess mortality and morbidity can be reduced, for example by focusing on interventions that can achieve the greatest health gains possible within the prevailing resource limits – the vast majority of preventable diseases are the result of a relatively small number of identifiable deficits, and hence a focus on communicable diseases, health awareness programs, and immunization programs can dramatically improve health and reduce premature mortality;

potential threats to health can be countered, for example by social marketing, with the goal of changing unhealthy environments and reducing risky behavior (e.g. environmental measures against vector-borne diseases like malaria as well as promotion of mosquito nets, the use of condoms as prevention against sexually transmitted diseases);

more effective health systems can be developed, for example by setting priorities according to actual needs and giving incentives to improve health sector performance (e.g. high priority for the known and cost-effective interventions against the diseases that cause 50% of preventable deaths among the poor); and

investments in expanding the knowledge base can be assured, for example through the analysis of the known "best practices" to learn from existing comparable national/local problems, and adopt cost-effective applications of what is useful, instead of "re-inventing the wheel": Successful programs and best practices on a variety of significant primary health issues are known to UNAIDS as well as to UNICEF and UNFPA, and they could be implemented if and when the political will to do so can be mobilized. Wherever known low-cost strategies to prevent or treat infectious diseases have been implemented, dramatic progress has been achieved—and yet, many countries still prefer not to follow World Health Organization (WHO) recommended policies.

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

Is there a right to health that poor people can call on pharmaceutical companies to sustainably respect? Yes, corporations all over the world and from all sectors have respective social and ecological legal duties within their normal business activities. Is there a right to health that poor people can call on pharmaceutical companies to sustainably *protect*? Yes, enlightened corporations strive to make sure that questionable labor standards and environmental practices are avoided in their sphere of influence. Novartis adheres to its self-imposed corporate citizenship norms even if local laws and regulations would allow for lower standards. Is there a right to health that poor people can call on pharmaceutical corporations to sustainably *fulfill*? Yes, for those who are employed by the company, through a fair remuneration. But beyond that?

The answer to this key question depends on whom you are asking. There is a widespread moral recognition of deliverables beyond the supply of markets, the respect of law and proper norms, and the provision of productive employment. Novartis does accept such responsibilities through the "can-dimension" of its corporate citizenship commitment. On its own, however, this cannot be more than a very limited contribution to overcome the challenges that we all face on a global level.

The huge mortality and morbidity burden can, however, only be brought down with a concerted strategy that is supported globally with financial resources as well as know-how on good practices and with national and community efforts to increase the access of the world's poor to essential health services. The international community's credibility will be measured in its willingness to deliver on commitments to increase external resources for development.

While it is reasonable and fair to expect that business enterprises who do not commit, become complicit, or benefit from violations of the political and civil rights of human beings anywhere in the world, the assessment of what is their reasonable and fair contribution to the respect, protection, and fulfillment of economic, social, and cultural rights remains more difficult. This is especially true for the right to health. Novartis' largest and most sustainable contribution toward this end is and will continue to be through its normal business activities: research, development, manufacturing, and selling pharmaceutical compounds to prevent premature mortality, to cure or alleviate diseases, to prevent or shorten hospitalization, and to contribute to the quality of life of sick

people. To do this while adhering to laws and regulations as well as being in harmony with internationally accepted labor and environment standards contributes further to the right to health of individuals and enables the state to fulfill its duties.

One thing is, however, obvious: Single actors on their own will face narrow limits with regard to their impact on global development and health problems. Solutions of multifaceted problems of global dimensions must be approached with a multi-stakeholder approach. This is why all actors of society – be they state or non-state – are called on to contribute to solutions according to their obligations, abilities, and enlightened self-interest. The watershed for the credibility for all societal actors will be their willingness to make resources available and to cooperate in meeting all the Millennium Development Goals – and in fulfilling the right to health.

Endnotes

1. The article is based on a larger version that was published in the UN Global Compact Quarterly, June 2005.
2. See http://www.enewsbuilder.net/globalcompact/e_article000375786.cfm?x=b4J1cSV,b3hPg0VQ
3. Article 1 of the Declaration on the Right to Development, adopted by General Assembly resolution 41/128 of 4 December 1986, reads "....States have the duty to co-operate with each other in ensuring development and eliminating obstacles to development. States should realize their rights and fulfill their duties in such a manner as to promote a new international economic order based on sovereign equality, interdependence, mutual interest and co-operation among all States, as well as to encourage the observance and realization of human rights."
4. For an interesting way to deal with this issue, see UNHCHR: *Human Rights Approach to Poverty Reduction Strategies*, at www.unhchr.ch/development/povertyfinal.html; see also OHCHR: *Human Rights and Poverty Reduction. A Conceptual Framework*. New York / Geneva 2004.
5. See Human Development Report 2003. UNDP, New York.
6. See Leisinger K.M.: *Health Policy for Least Developed Countries*. Basel (Social Strategies, Vol. 16) 1985 (available through the Novartis Foundation for Sustainable Development, CH-4002 Basel).
7. See Carr D.: Improving the Health of the World's Poorest People. In: Population Reference Bureau: *Health Bulletin*, Vol. 1 (2004), No. 1, p. 14.
8. See Leisinger K.M. / Schmitt K. / Pandya-Lorch R.: *Six Billion and Counting. Population and Food Security in the 21st Century*. IFPRI/Johns Hopkins University Press, Washington DC 2002; Population Reference Bureau: Transition in World Population. In: *Population Bulletin*, March 2004, p. 32.
9. See, for best practices, www.sarvodaya.org.
10. WHO: *25 Questions & Answers on Health & Human Rights*. Geneva 2002, p. 10.
11. UNDP: *Human Development Report 2003. Millennium Goals: A Compact Among Nations to End Poverty*. Oxford University Press, New York 2003, p. 101.
12. Commission on Macroeconomics and Health: *Macroeconomics and Health: Investing in Health for Economic Development*. WHO, Geneva 2002, Foreword.
13. See Bloom D.E. / Canning D. / Jamison D.T.: Health, Wealth, and Welfare. In *Finance & Development* Vol. 41 (2004), No. 1, pp. 10–15.
14. I owe this definition to Interim report of the Special Rapporteur of the Commission on Human Rights on the Right of Everyone to Enjoy the Highest Attainable Standard of Physical and Mental Health, Paul Hunt (A/58/427), United Nations, New York 2003, the 2003 Interim report of Paul Hunt, the UN Special Rapporteur for the Right to Health, p. 13.
15. For details, see the project sites on www.novartisfoundation.com.
16. Interim report of the Special Rapporteur of the Commission on Human Rights on the Right of Everyone to Enjoy the Highest Attainable Standard of Physical and Mental Health, Paul Hunt (A/58/427), United Nations, New York 2003, p. 21.
17. See the joint report on orphans estimates and program strategies by UNAIDS, UNICEF, and US Agency for International Development: *Children on the Brink 2002*. Washington DC 2002.
18. Carrin and James calculate that for the countries in Africa with GDP per head of less than $1,000, 45–50 years must elapse before the institution of compulsory universal coverage. This is particularly the case for the population of the agricultural and informal sector, as these groups have fluctuating incomes that are difficult to estimate for a regular contribution. See Carrin G. and James Chr.: *The Determinants of Universal Coverage: An Empirical Analysis*. WHO, unpublished document. Geneva 2000, pp. 205ff.
19. See www.novartisfoundation.com/basic_health_care/index.htm.
20. See Sachs, J. and P. Malaney: The Economic and Social Burden of Malaria. In: *Nature*. Vol. 415 (2002), pp. 680–85.
21. See WHO: *World Health Report 2000: Health Systems: Improving Performance, Geneva 2000, Chapter 4.*
22. Spinaci S. / Heymann D.: Communicable Disease and Disability of the Poor. In: *Development*, Vol. 44 (2001), No. 1, pp. 66ff.
23. See WHO: Removing Obstacles to Healthy Development, Geneva 1999, pp. 18ff.
24. Baird M. / Shetty S.: Getting There. How to Accelerate Progress Toward the Millennium Goals. In *Finance & Development*, December 2003, p. 15f.