

World Poverty & Human Rights

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1

The Human Cost of World Poverty

The Effects of World Poverty

Among ca. 6800 million human beings, about
1020 million are chronically undernourished (FAO 2009)
2000 million lack access to essential drugs
(www.fic.nih.gov/about/plan/exec_summary.htm),
884 million lack safe drinking water (WHO/UNICEF 2008, 32),
924 million lack adequate shelter (UN Habitat 2003, p. vi),
1600 million have no electricity (UN Habitat, "Urban Energy"),
2500 million lack adequate sanitation (WHO/UNICEF 2008, p. 7),
774 million adults are illiterate (www.uis.unesco.org),
218 million children (aged 5 to 17) do wage work outside their household — often under slavery-like and hazardous conditions: as soldiers, prostitutes or domestic servants, or in agriculture, construction, textile or carpet production (ILO: *The End of Child Labour, Within Reach*, 2006, pp. 9, 11, 17-18).

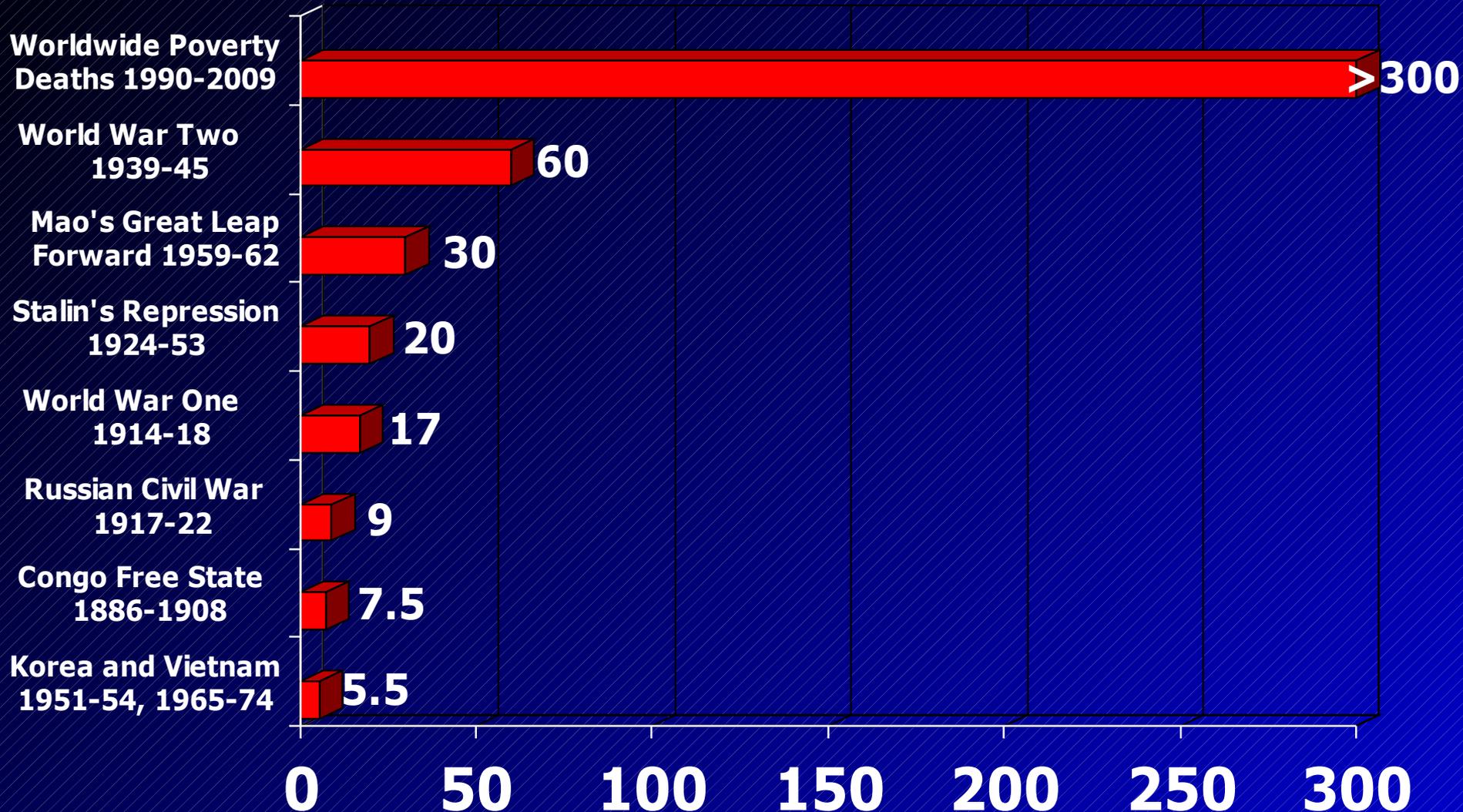
At Least a Third of Human Deaths

— some 18 (out of 57) million per year or 50,000 daily
— are due to poverty-related causes, cheaply preventable through safe drinking water, better sanitation, more adequate nutrition, rehydration packs, vaccines or other medicines. In thousands:

diarrhea (2163) and malnutrition (487),
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HIV/AIDS (2040), sexually transmitted diseases (128)

WHO: World Health Organization, Global Burden of Disease: 2004 Update, Geneva 2008, Table A1, pp. 54-59 .

Millions of Deaths



The Human Right Least Realized

“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.”

Article 25(1), *Universal Declaration of Human Rights*, 1948

2

The Economic Magnitude of World Poverty

IPL Level and Global Poverty Gap

IPL in 2005 int'l dollars per person per day	Poor People in 2005		Aggregate Shortfall from the IPL		
	Number in billions	Average Shortfall from the IPL	in percent of gross global income		in \$bn p.a.
			at PPPs	at current (2005) exchange rates	
\$1.25	1.38	30%	0.33%	0.17%	76
\$2.00	2.56	40%	1.28%	0.66%	296
\$2.50	3.08	45%	2.2%	1.13%	507

3

Globalization as Part of the Explanation

Three Claims

- Today, most premature human deaths and other deprivations are causally traceable (“but for”) injustice in existing supranational institutional arrangements
- for which the more powerful countries and their citizens are responsible
- in violation of human-rights-correlative negative duties of justice.

Counter-Argument

Poverty is evolving differently in the various developing countries and regions. This shows that *local* (e.g., national) factors account for the persistence of severe poverty where it persists.

Conceptual Answer to the Counter-Argument

It merely shows that local factors are co-responsible for the persistence of severe poverty. It does not show that local factors are solely responsible.

Example: Differential learning success of students/pupils in the same class.

Empirical Answer to the Counter-Argument: Specific Examples of Poverty-Aggravating Global Institutional Arrangements

Global institutional order works against HR fulfillment directly: **rules of trade and finance** (with asymmetrical protectionism); **permissive environmental rules** (fostering greenhouse gases and resource depletion).

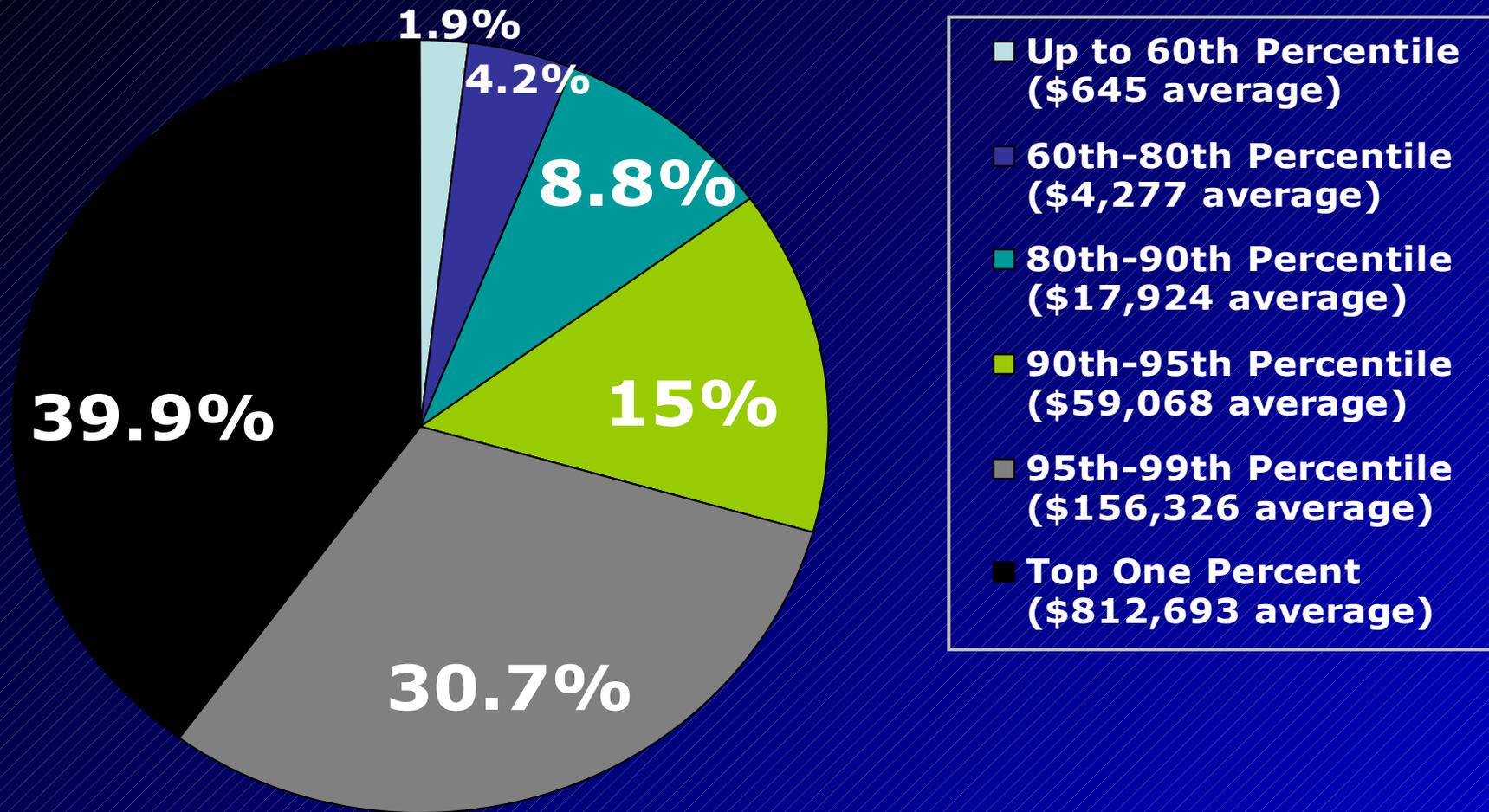
... works against HR fulfillment indirectly, by incentivizing and sustaining HR-violating regimes and policies in poor countries: **international resource, borrowing, treaty, arms privileges; intellectual property rights in seeds and medicines; "race to the bottom" in labor standards.**

The facilitation of **illicit financial flows** exemplifies both: draining poor countries of revenues through tax evasion and embezzlement (US\$850-1000 billion p.a.) and fostering corruption and oppression in those countries.

www.ffdnngo.org/documentrepository/GFI%20Report.pdf.

Segment of World Population	Global Household Income 1988	Global Household Income 2002	Absolute Change in Income Share	Relative Change in Income Share
Richest Ventile	42.87	48.80	+5.93	+13.8%
Next Four Ventiles	46.63	42.78	-3.85	-8.3%
Second Quarter	6.97	5.44	-1.53	-22.0%
Third Quarter	2.37	2.06	-0.31	-13.1%
Poorest Quarter	1.16	0.92	-0.24	-20.7%

Shares of Global Wealth 2000; poorest versus richest households



Calculated in market exchange rates so as to reflect avoidability of poverty. Decile Ineq. 2837:1. Quintile Ineq. 85:1. Year 2000, \$125 trillion total.

4

Responsibilities

Human Rights as Moral Claims on (Global) Institutional Arrangements

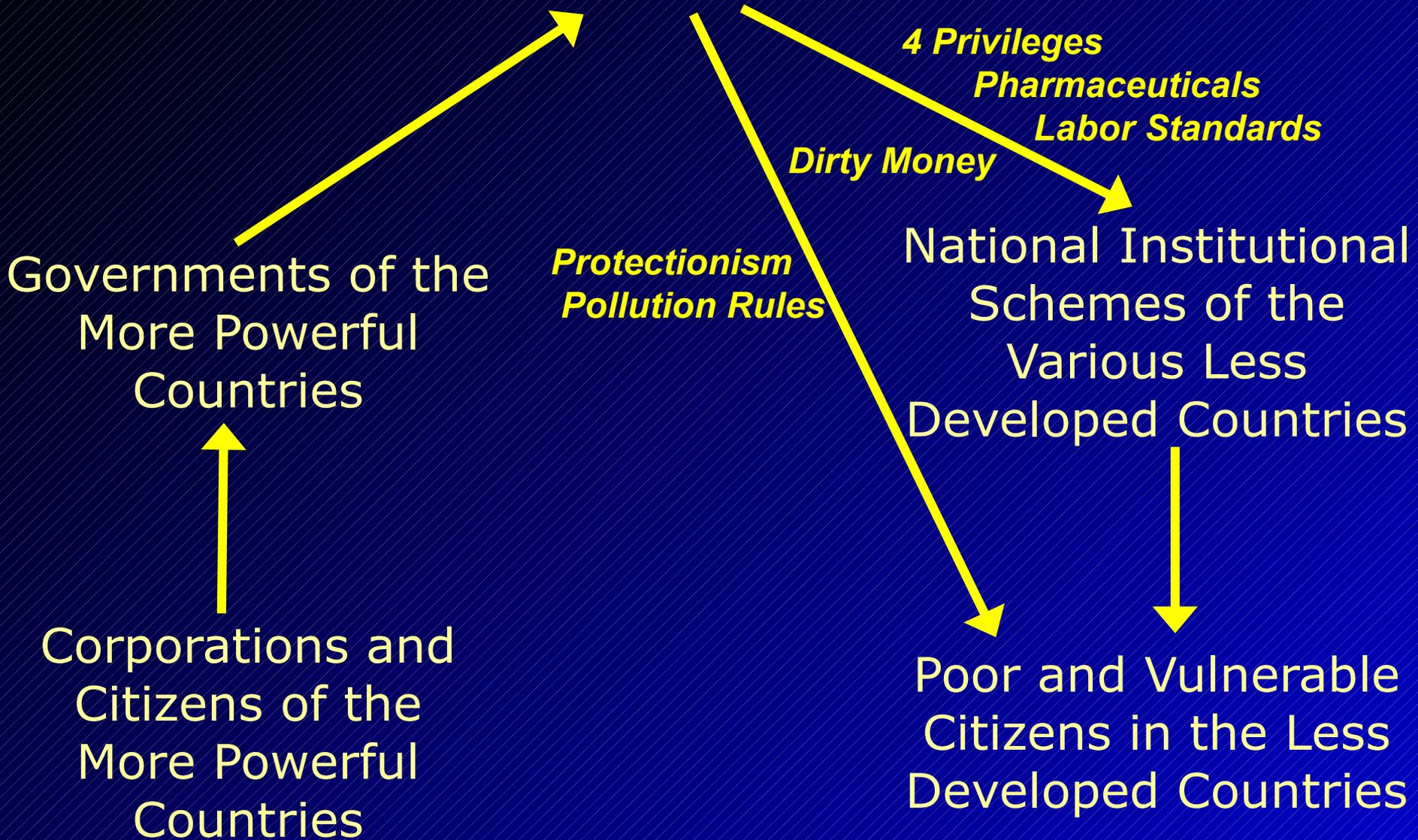
“Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.”

Article 28, Universal Declaration of Human Rights, 1948

Moral Responsibility

When an institutional order is unjust (e.g., by foreseeably producing massive and foreseeably avoidable human-rights deficits), then those who – without compensating reform and protection efforts – are actively cooperating in designing or imposing this order are *harming* (e.g., *violating the human rights of, violating a human-rights-correlative negative duty toward*) those who suffer the avoidable human-rights deficits.

Global Institutional Order



5

**Official Response:
“halving poverty
and hunger”**

The Grand Promise to Halve Poverty by 2015: *Three Versions*

1996 World Food Summit in Rome: the **number** of extremely poor is to be halved during **1996-2015**. This implies an annual reduction by **3.58%**.

(www.fao.org/wfs)

2000 Millennium Development Goal 1 (MDG-1): the **proportion** of extremely poor among the **world's people** is to be halved **2000-2015**. This implies annual decline by **3.35%** (40% in 15 yrs).

MDG-1 as subsequently revised by the UN: the **proportion** of extremely poor among the **population of the developing countries** is to be halved **1990-2015**. This implies an annual reduction by **1.25%** (27% over 25 years).

MDG-1: A Promise Diluted

	Baseline Year	Baseline Number of Poor (millions)	Promised Reduction in number by 2015	Target for 2015 (millions)	Required annual rate of reduction
World Food Summit	1996	1656	50% in 19 yrs	828	3.58%
Millennium Declaration	2000	1665	40% in 15 yrs	999	3.35%
MDG-1 as now tracked	1990	1813	27% in 25 yrs	1324	1.25%

Changes in World Poverty

<i>IPL at 2005 PPPs</i>	<i>1981-2005</i>	<i>1984-2005</i>	<i>1987-2005</i>	<i>1990-2005 (-17.2%)</i>	<i>Relative to path of diluted MDG-1</i>	<i>1993-2005</i>	<i>1996-2005</i>	<i>1999-2005</i>
\$1.25	-27%	-24%	-20%	-24%	40% ahead	-23%	-17%	-19%
\$2.00	+1%	-2%	-3%	-7%	59% behind	-9%	-9%	-11%
\$2.50	+13%	+8%	+5%	+45%	103% behind	-3%	-5%	-7%

“Updating” the World Bank’s International Poverty Line

Used from 1990 until 1999:

1.02 1985-dollar per day, **today \$2.03** in US

1.00 1985-dollar per day, **today \$1.99** in US

Used from 2000 until 2008:

1.08 1993-dollar per day, **today \$1.60** in US

Used since August 2008:

1.25 2005-dollar per day, **today \$1.37** in US
or **\$9.59** per week or **\$500** annually

www.bls.gov/data/inflation_calculator.htm

6

**Where Should
We Focus our
Reform Efforts?**

On a Political Reform that

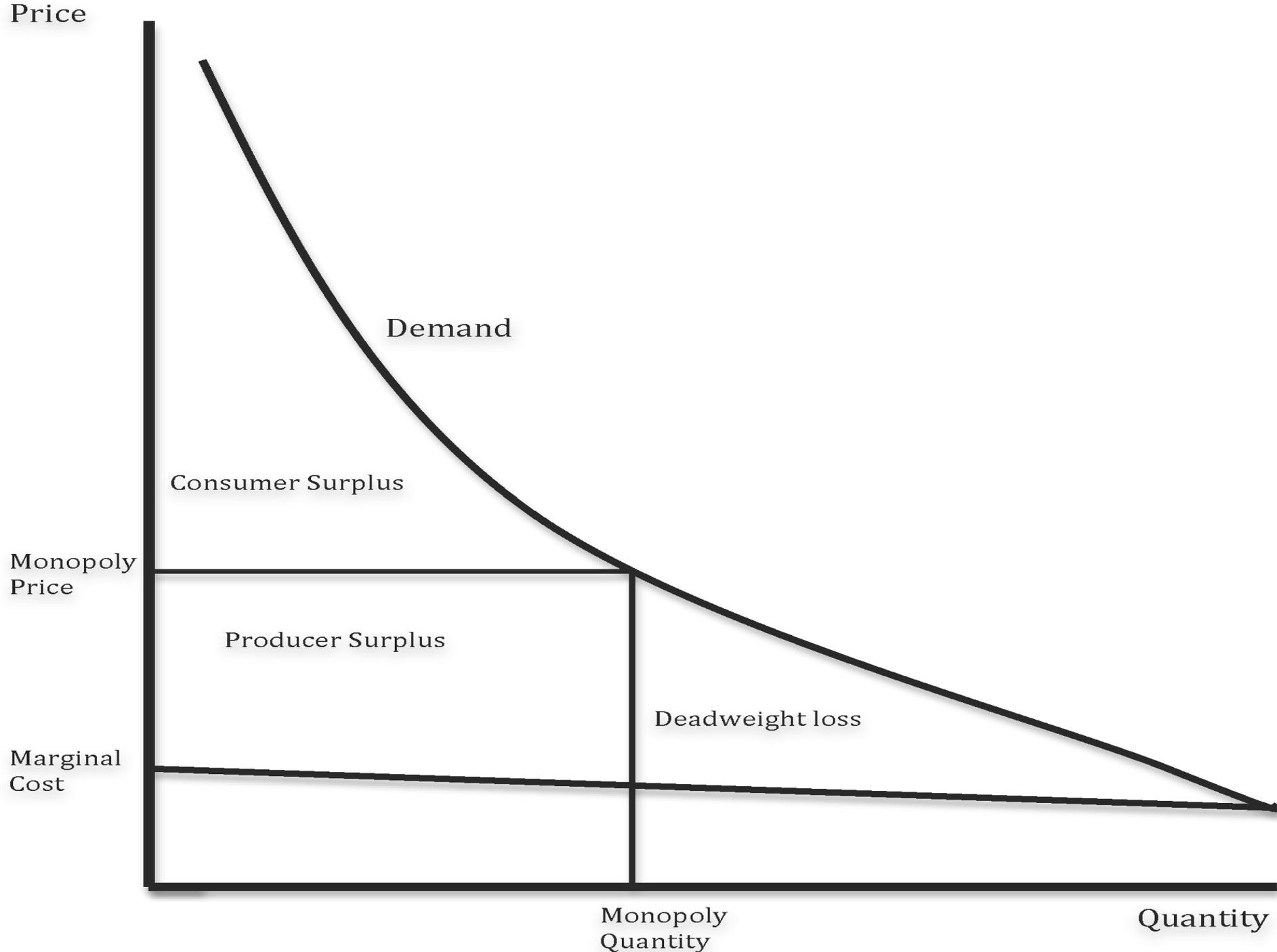
- constitutes an enduring *structural* reform;
- effectively symbolizes the idea that all human lives are of equal value, genuine moralization;
- benefits a strong, well-organized faction of the global elite (new profit opportunities, image improvement);
- is scalable and can be increased and/or adjusted as experience warrants;
- strengthens those with an objective interest in reform (empowerment of the global poor);
- is exemplar of realistic moral leadership, reproducible creation of a global public good. 26

The Health Impact Fund (HIF)

- Funded by willing governments at minimally **\$6 billion** per annum (0.01% of GNI, if universal)
- Promises to reward (upon registration) any new medicine on the basis of its **global health impact**
- Registering a new medicine with the HIF is **voluntary** for the innovator, who need not give up any intellectual property rights
- Registrant must agree to make the new medicine available wherever it is needed at the **lowest feasible cost of manufacture and distribution** and to grant zero-priced licenses after reward period
- www.HealthImpactFund.org

Financing

- \$6 billion a year is about 0.01% of global income, not even 1% of current worldwide expenditures on pharmaceuticals.
- Full incentive effects on potential innovators require long-term commitment by funders.
- Only governments (of affluent and developing countries) can plausibly commit large sums long-term. We propose a small share of GNI, perhaps 0.03%, for each partner country.
- All or most of this comes back to taxpayers through lower prices for medicines, insurance, national health systems, and foreign aid.



The HIF Resolves Three Critical Problems in Prize Determination

*Which health problems to target;
how to define the "finish line";
how large to make the reward (self-adjusting).*

The HIF is a market-based solution: payments are determined by competition among all registered products for the available rewards.

- A drug for malaria can directly compete against a drug for HIV/AIDS.
- This regulates relative rewards for registered products, rewarding each at the same rate per unit of health impact, creating efficient incentives.

7

**Why a Complement
to TRIPS is Needed**

Rules Governing the Development and Distribution of New Medicines

Under the TRIPS agreement – part of the WTO Treaty and a paradigm example of regulatory capture – the intellectual property regime of the affluent countries was globalized by being made a mandatory condition of WTO membership.

Pharmaceutical innovators must be granted 20-year product patents in all WTO member states.

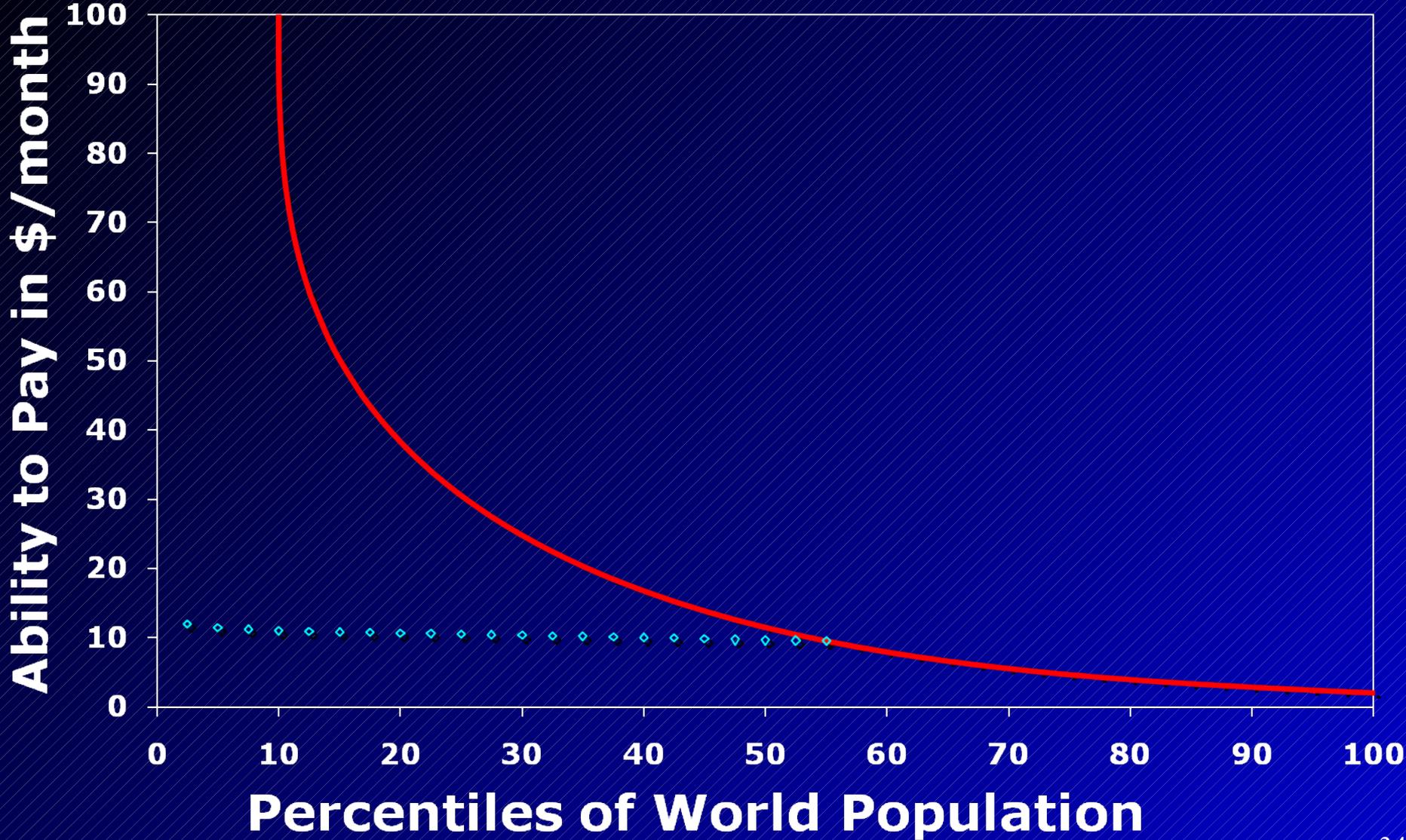
Seven Problems with TRIPS-Pure

1. High prices impede **access** by poor people for the duration of the patent

Why are prices so high?

Patented medicines for global diseases are priced to maximize profit (= mark-up times sales volume). For important medicines, optimal mark-up is high because of high economic inequality and low price elasticity among the affluent.

Global Pharmaceutical Demand Curve



Seven Problems with TRIPS-Pure

2. Pharmaceutical *innovation* is neglecting diseases concentrated among the poor.

Why?

Medicines for such diseases are not lucrative targets for pharmaceutical R&D: innovator gets tiny mark-up or tiny sales volume.

Distribution of Pharma Research

Diseases accounting for 90% of the global disease burden receive only 10% of all medical research worldwide. Pneumonia, diarrhea, tuberculosis and malaria, which account for over 20% of the global burden of disease, receive less than 1% of all public and private funds devoted to health research. Of the 1556 new drugs approved between 1975 and 2004, only 18 were for tropical diseases and 3 for TB.

TRIPS-Pure (*versus* TRIPS+HIF)

1. High prices impeding access by the poor
2. Neglected diseases (90/10 Problem)
3. Bias toward maintenance drugs
4. Patenting, litigation, deadweight losses
5. Cost-price diff'l □ excessive marketing
6. Cost-price differential ▪ counterfeiting
7. Last-mile problem, perverse incentives

The HIF Reduces the “Last Mile Problem” in Drug Delivery

Proper prescribing and compliance are essential to drug effectiveness.

The HIF pays on the basis of each medicine’s **actual** health impact as assessed not only through sales data, but also through sampling of actual use and benefits as well as through population health data.

Firms therefore have incentives to promote appropriate use of their registered products, as well as to develop products that are effective in resource-poor settings.

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8

**The Larger
Picture**

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Two Different Adaptations

Extension to clean/green technologies: free access to patented knowledge in exchange for rewards proportioned to emissions averted.

Offer to pay innovator for introducing a new drug to India on the basis of its demonstrated health impact in India (fixed INR/QALY rate) on condition that the innovator makes the product available all over India at a price no higher than the lowest feasible cost of manufacture and distribution.

THANK

YOU

9

**More Details
about the HIF**

Metric for Assessing Health Impact

Health impact is to be assessed in QALYs through comparison to outcomes that could have been expected to occur given the state of technology two years before the drug was introduced, and excluding the firm's own products.

Quality-Adjusted Life Years: All health states are rated on a 0-1 scale. For example, 2 QALYs

= two extra years in good (1.0) health

= four extra years in poor (0.5) health

= ten years in improved (+0.2) health.

How to Assess Health Impact

Health impact is to be assessed annually based on collected data and inference

Assessment will rely on data from

- Clinical trials
- Pragmatic or practical trials
- Audited data on sales aided by serial numbers on packages and mobile phone technology
- Stratified sampling of use of the product in different environments
- Global burden of disease data

Assessment Cost

- The assessments would be expensive to run, consuming up to 10% of the fund payout, or \$600 million per year. Judged to be feasible by experts (IHME)
- Better health impact monitoring is a priority in almost all countries already.
 - Clinical reasons
 - Budgetary reasons
- Assessment costs are therefore partly balanced by collateral benefits.