

Decoding the right to health: What could it offer to global health?

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Abstract

The meaning of a right to the highest attainable standard of health has been subject to considerable debate: what are the precise entitlements and duties that this right creates, are these rights and duties legally enforceable, and would enforceable rights to health hamper or advance health equity? To respond to some of these questions, this paper overviews the legal evolution and construction of the right to health in international human rights law, and assesses its potential contribution to advancing equitable health goals. The paper first outlines the evolution of the international human rights legal framework relevant to health. Second, it overviews the contribution of this framework to advancing health equity in a variety of fora, from domestic litigation, to rights-based policy tools, to guiding the formulation of global health policy mechanisms like the current Sustainable Development Goals. The paper concludes that if these social and legal mechanisms can be activated, the right to health may offer an increasingly powerful framework for advancing health equity globally.

Key words: right to health, international human rights law, global health, health equity

Introduction

The contribution of human rights to advancing global health policy and equity has become a significant focus of scholarship and practice, focusing on its contribution to the social determinants of health [1], global health diplomacy [2], globalization [3], and health litigation [4]. The question of the contribution of rights and in particular, the right to health, is particularly prominent as governments gear up to negotiate health goals for the Sustainable Development Agenda (SDG). Yet the meaning of a right to the highest attainable standard of health has been subject to considerable debate: what precise entitlements and duties does this right create, are these rights and duties legally enforceable, and would enforceable rights to health hamper or advance health equity? The question remains for many inside and outside this field: has the legal, social and political interpretation and enforcement moved this right beyond ongoing perceptions that it is an “empty aspirational slogan” [5]?

In order to respond to some of these questions, this paper overviews the legal evolution and construction of the right to health in international human rights law,

and assesses its potential contribution to advancing equitable health goals by overviewing key social and legal variables capable of accessing the legal and normative power of this framework. I first outline the evolution of the international human rights legal framework relevant to health, and the development of mechanisms such as the Special Rapporteur on the right to health. I then overview the contribution of this framework to advancing health equity in a variety of fora, from domestic litigation, to rights-based policy tools, to guiding the formulation of global health policy mechanisms like the current SDG.

The international legal evolution of the right to health

The evolution of the international right to health is rooted in the genesis of the United Nations system itself, and the significant human rights system it created. The following section overviews the evolution of this right through international human rights treaties, its authoritative interpretation in the UN Committee on Economic, Social and Cultural Rights’ General Comment 14, and the creation of a UN Special Rapporteur on the right to health.

(a) International human rights treaties

The *Charter of the United Nations* [6] establishes as a founding purpose of the United Nations the achievement of “international cooperation [...] in promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction as to race, sex, language, or religion” [6]. The UN Charter doesn’t define what human rights are, but does posit as a UN objective to promote “solutions of international economic, social, health, and related problems” [6]. To promote this objective, the World Health Organization was established in the 1946 *Constitution of the World Health Organization* (WHO Constitution) to achieve health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” [7]. The Constitution provided the first international expression of a health right, recognizing that “the enjoyment of the highest attainable standard of health is a fundamental right of every human being without distinction of race, religion, political belief, economic or social condition” [7]. In addition, the

Constitution recognized that governments have a responsibility “for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures” [7].

The right to health was further developed in the *Universal Declaration of Human Rights* (UDHR), the first international human rights bill [8]. The UDHR recognizes in article 25.1 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” [8]. By including medical care within the minimum social and economic conditions necessary for health, the UDHR provided parameters for achieving the highest attainable standard of health [9]. The ideological conflicts of the Cold War ambushed the UN’s ambition of turning the UDHR into a single treaty, and instead these rights were separated into two treaties in the form of the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) [10] and the *International Covenant on Civil and Political Rights* (ICCPR) [11]. The ICESCR contains the most authoritative international health right. In article 12 of the ICESCR, states recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. In addition, this article identifies steps states must take to realize this standard, including reducing the stillbirth rate and infant mortality; improving all aspects of environmental and industrial hygiene; preventing, treating, and controlling epidemic, endemic, occupational, and other diseases; and creating conditions that assure medical services and attention to all in the event of sickness.

However, these duties are limited in article 2 of the ICESCR to a state obligation to

take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of [their] available resources, to achieve progressively the full realization of Covenant rights by all appropriate means, including particularly legislation.

This limitation of state duties to progressively realize the right to health within available resources places significant constraints on the ambitious aspirations of everyone’s right to the highest attainable standard of health. Moreover, neither article 12 on the right to health nor article 2 on state duties provide much clarity to ratifying states on the scope and content of individual entitlements or state duties towards health. The task of interpretation has been taken up by subsequent treaties and by the CESCR and a UN Special Rapporteur on the right to health.

Some clarity has emerged in subsequent human rights treaties that entrench rights relevant to health for vulnerable groups including racial minorities, women, children, and people with disabilities [12–15]. These international and regional treaties have expanded the

scope of the right to health, albeit that sometimes these treaties are limited to specific populations or geographic locations. The task of elucidating the scope and content of ICESCR’s article 12 remained essential, and this fell to the United Nations Committee on Economic, Social and Cultural Rights (‘CESCR’ or ‘the Committee’), the body tasked at the UN with overseeing state compliance with the ICESCR.

(b) General Comment 14 on the Right to the Highest Attainable Standard of Health

In 2000 the CESCR extensively interpreted the right to health in a general comment on article 12 [16]. The Comment makes several important conceptual advances in interpreting the right to health, defining its normative scope, identifying entitlements, essential elements and state obligations. The General Comment has been an extremely important interpretation of the ICESCR’s right to health, and provides vital guidance to policy-makers, judges and civil society in realizing, enforcing and claiming this right. It goes a significant way towards resolving the long-standing vagueness of the right to health that has plagued its enforcement in legal and policy arenas.

The Committee is explicit that the right is not an entitlement to being healthy, but rather an inclusive right to healthcare and the underlying determinants of health (including food, housing, access to water and adequate sanitation, safe working conditions, and a healthy environment) [16]. While the highest attainable standard of health and the health system will vary from country to country depending on national resources, the Committee emphasizes that the right must contain certain essential elements irrespective of a country’s developmental levels [16]. These essential elements include that healthcare facilities, goods, and services, and the social determinants of health are available, accessible, acceptable, and of good quality, a set of considerations known widely as the ‘AAAQ framework’ [16].

The Committee also identifies core obligations with which a state party cannot “under any circumstances whatsoever, justify [...] non-compliance” [16]. Core obligations are intended to preclude states from citing progressive realization within available resources to deny any level of healthcare, particularly those necessary to address the essential health needs of the most vulnerable. States’ core obligations are to “ensure the satisfaction of, at the very least, minimum essential levels of each of the rights”, including non-discriminatory access to health facilities, goods, and services; access to minimum essential food; access to basic shelter, housing, and sanitation and an adequate supply of safe and potable water; essential drugs as defined by the WHO; equitable distribution of all health facilities, goods, and services; and adopting and implementing a national public health strategy and plan of action addressing the health concerns of the whole popula-

tion, with particular attention to vulnerable or marginalized groups [16]. The Committee also identifies as obligations of comparable priority to core duties taking measures to prevent, treat, and control epidemic and endemic diseases, and ensuring reproductive, maternal (prenatal as well as postnatal), and child healthcare [16].

Progressive realization is interpreted to require states to take immediate action towards realizing the right to health, including by guaranteeing the non-discriminatory exercise of rights and by taking deliberate, concrete, and targeted steps towards full realization [16]. Thus, while states could conceivably justify continuing healthcare deficiencies under progressive realization, they could justify a failure to work towards rectifying them. This clarification seeks to guide states in what duties of progressive realization require, and to counter perceptions that progressive realization could justify indefinitely delaying taking action [9].

General Comment 14 provides detailed interpretations of state obligations to respect, protect, and fulfill the right to health [16]. The state duty to *respect* the right to health requires that governments do not interfere with this right, for example through discriminatory policies, or those likely to cause unnecessary morbidity and preventable mortality [16]. The state duty to *protect* the right to health requires states to ensure equal access to health services provided by third parties, including by controlling third party marketing and provision of health goods and services [16]. State duties to *fulfill* the right to health arise “when individuals or a group are unable, for reasons beyond their control, to realize that right themselves by means at their disposal” [16]. These duties have important implications for how alternative political or commercial interests are balanced in health-related decision-making at all levels, particularly given the health and developmental impacts of globalization [17].

In assessing whether actions or omission constitute violations of the right to health, the Committee distinguishes between non-compliance arising from unwillingness rather than inability [16]. At the same time, the Committee explicitly identifies international duties to respect, protect and fulfill the right to health: states must respect the right to health in other countries, they must protect the right by preventing third parties from violating it elsewhere if states can influence them by legal or political means [16]. In particular, “depending on the availability of resources, States should facilitate access to essential health facilities, goods and services in other countries, where possible and provide the necessary aid when required” [16].

(c) The Special Rapporteur on the right to the highest attainable standard of physical and mental health

In 2002, the first Special Rapporteur on the right to health was appointed by the UN, with the mandate of promoting the development and realization of this right

globally. Since that time, there have been three Special Rapporteurs: Paul Hunt, a New Zealand law professor in England (2002–2008), Anand Grover, an Indian lawyer and HIV/AIDS activist (2008–2014), and the incumbent, Danius Pūras, a Lithuanian professor of child psychiatry and former member of the UN Committee on the Rights of the Child. Each have brought their own specific priorities to the mandate: as the first Rapporteur, Paul Hunt’s focus was to clarify the normative framework of the right to health insofar as possible; Anand Grover’s tenure expanded this work, while focusing in on issues like access to medicines and trade-related intellectual property rights, and the right to health aspects of sexual orientation, sex work and HIV transmission. Danius Pūras has identified overarching themes for this work including health systems, sexual and reproductive health rights, the needs of children and adolescents, those in vulnerable situations, and persons with disabilities. He indicates that he plans to prioritize a policy approach that analyzes the processes and outcomes of policies as well as implementation gaps.

The creation of this position is an important recognition from the UN of the importance of this right, and has enabled considerable international attention on further developing and applying it. The Special Rapporteur on the right to health has three main objectives: (1) *to promote and encourage the promotion of the right to health as a fundamental human right*; (2) to clarify specific elements and the general content of the right to health; and (3) to identify good practices at the community, national, and international levels for the operationalization of the right to health, and to receive individual complaints, which the Rapporteur is to follow up on and make publicly available once a year [18]. In compliance with this mandate, the Special Rapporteur undertakes country missions and other visits, transmits communications to governments about alleged violations of the right to health, and submits annual reports to the Human Rights Council and the General Assembly detailing activities performed under the mandate and information on relevant issues (including poverty, international trade, health systems, mental health, access to medicines, neglected diseases and sexual and reproductive health [19]. In addition, the Special Rapporteur undertakes country missions and missions to international organizations and non-state actors (including the World Bank and International Monetary Fund in 2007, and GlaxoSmithKline in 2008). These missions are particularly significant since they expand international human rights law beyond its state-centric orientation, which traditionally has a limited application to non-state actors such as international organizations and corporations [20]. The Special Rapporteur procedure is an important mechanism for developing the right to health within international law, which has contributed to the development of new right-to-health tools, such as human rights indicators [21].

Mechanisms for realizing the right to health

Growing legal clarity on the right to health has led to an increase in legal enforcement, as well as the development of tools for realizing this right and thereby holding states accountable for their legal duties. This clarity comes at the same time that 164 states have ratified the ICESCR [22]. Ratification is the process whereby states become legally bound by treaties, and this figure indicates that two thirds of all states hold legal obligations under the ICESCR's right to health. Yet ratification alone does not assure that policy-makers or domestic judges will take treaty obligations seriously or realize the right to health along with other ICESCR rights. Indeed, the ratification of human rights treaties is argued to have limited impact on population health [23]. The increasingly specific norms of the right to health therefore require several mediating mechanisms and variables to translate treaty rights into material gains. I argue that these mechanisms are capable of responding to some of the legal, political, economic and cultural challenges that can stymie “the immense promise [of the right to health] as a normative [...] and [...] operational framework” [5]. Through these approaches, actors can access the potential power of the right to health, which prominent scholars recognize is “uniquely positioned to catalyze progress” towards a more ‘just’ global health [24]. In the following section, I overview several of the mechanisms and variables that are translating ICESCR norms into tangible benefits at the domestic and global levels, focusing on human rights litigation, advocacy, and rights-based policy tools like right-to-health indicators. Finally, I explore the normative influence of increasingly clear specifications of the right to health in guiding various formulations of health goals for the SDG process. Each of these examples illustrates how the international right to health can play a role in advancing health equity.

(a) Domestic litigation

The enforcement of health rights in national courts remains the most formally binding method of enforcing the right to health. Over the past two decades, there has been a tremendous increase in national cases on the right to health, including in low- and middle-income countries [25–28]. These cases have addressed a broad range of health issues, enabling litigants to access antiretroviral (ARV) drugs for people with HIV/AIDS; prisoners to access healthcare; access to generic drugs; battles over reproductive rights; and efforts to secure social determinants of health, including water, food, and a healthy environment [28]. It is notable that a consistent variable in successful right-to-health litigation is that the country in question has both ratified the ICESCR and entrenched a domestic constitutional right to health [26]. This finding suggests that the legal force of treaty ratification is amplified when treaty rights are replicated in domestic laws, making domes-

tic judges less likely to reject treaty duties as domestically unenforceable.

Yet evidence on the impacts of this litigation on health outcomes is mixed. On the positive side, South Africa illustrates how domestic litigation can produce outcomes that are beneficial for individual and population health. In 2002, the South African Constitutional Court upheld civil society claims under constitutional and international protections of rights to health and life for the government to provide medicines to prevent mother-to-child transmission (MTCT) of HIV [29]. As a result of the case, by 2010 a national MTCT program was providing these medicines in over 96% of government clinics [30]. Similarly successful litigation in Latin America has shown how enforcing human rights can both improve access to healthcare and increase budgetary allocations for health [31]. In the 1998 case of *Mariela Viceconte v. Ministry of Health and Social Welfare*, an Argentinian court found government liable to provide adequate access to preventative vaccines to 3.5 million people living in an area affected by hemorrhagic fever. As a result of the case, Argentina's government developed a plan to deliver basic medicines to those in need within five years of the ruling [31].

Yet domestic litigation has sometimes had less positive collective impacts. In Colombia, overwhelming numbers of health rights claims have been lodged under the tutela system (an informal and fast-track petition procedure without precedential value) [32]. As a result, between 1999 and 2010, 869,604 right-to-health claims were lodged through this mechanism [32]. Some view these cases as detrimental to equity by giving generous concessions to individual claims irrespective of their resource implications [33]. Nonetheless, others suggest that these massive rates of right-to-health litigation did not create systemic disfunction and inequity rather than respond to them [33]. It is therefore significant that in 2008, the Colombia Constitutional Court ordered both institutional reform to reduce tutela rates and extensive restructuring of Colombia's health system [34]. Certainly the Colombian experience suggests that “successful” cases that favor individual or group claimants at the expense of collective interests may not be conducive to good public health [20]. It nonetheless underscores the important role of courts in advocating for health equity within the policy process. Moreover, as both the South African and Colombian structural order attest, individual and group claims can benefit collective health interests and potentially assist in reducing systematic disparities in healthcare access [17]. As Flood and Gross suggest in their comparative study of right-to-health litigation in 16 countries globally, that even acknowledging the challenges, “wherever possible, courts should both protect and assist the democratic process of establishing universality, equal access, and reasonable coverage for health care” [35].

(b) Rights-based advocacy

International human rights law provides strong support for social advocacy for global health equity by providing a normative specificity and analytic framework grounded in binding law. The potential is to affect a paradigmatic shift from viewing health as a charitable and/or superfluous component of budgetary allocations to one implicating binding legal and moral duties [20]. The HIV/AIDS treatment advocacy campaigns of the 2000s illustrate the strengths of rights-based advocacy. Here civil society actors used rights-based strategies, including litigation and advocacy, to challenge the pharmaceutical industry, their host governments, and international institutions to advance affordable ARV drugs in sub-Saharan Africa where almost 30 million people were infected with HIV. These actions achieved a dramatic global reduction in the price of ARV drugs, and corporations, governments, and international organizations shift towards advocating universal access to ARV drugs [17]. Access to ARV drugs in sub-Saharan Africa has increased from under 1% to over 78% in ten years, with almost 13 million people currently accessing drug treatment [36]. Increased access to ARV drugs is producing tremendous health impacts, including a 22% decline in AIDS-related deaths between 2009 and 2013 [36], declines in overall death rates since 2005 [37, 38], and a one-third decline in deaths from HIV-associated tuberculosis from 2004 to 2013 [36].

The AIDS treatment campaign succeeded not simply in achieving transformative material gains in low and middle incomes countries globally, but in pushing broad acceptance of access to AIDS medicines as a fundamental human right [17]. These gains are understood to extend even more broadly in the global health arena: as WHO indicates “HIV advocacy has sharpened awareness of the importance of health equity, gender equality and human rights – in their own right and for public health” [36]. In the AIDS treatment campaign as in the litigation outlined above, civil society has played a vital role, mobilizing social movements in support of key right-to-health claims and challenging governments and private actors in domestic courts. These experiences intimate that law alone is an insufficient causal mechanism for advancing transformative human rights change, and that social action is key to achieving such outcomes [39, 40]. Indeed, a growing area of scholarship focuses on the causal role of social action in producing international law “from below” [41, 42].

(c) Rights-based policy and tools

Rights can work more systematically to advance health equity than the intermittent incidence and narrow scope of litigation or even issue-based advocacy may permit [17]. Given that litigation and advocacy have necessarily limited scope, human rights scholars have developed rights-based versions of public and global health policies, programs, and tools. Rights-based approaches seek to concretize political commitments to

health equity by: (i) mandating the incorporation of core human rights principles (such as non-discrimination, participation, and accountability); (ii) demanding a focus on poor and marginalized groups; and (iii) requiring explicit reference to international human rights instruments [43]. Indeed human rights scholars argue that in the same way that the right to a fair trial has advanced well-functioning court systems, the right to health has a particular contribution to make to promoting policies that advance health equity [21]. A 2008 study by Backman and colleagues identified the right-to-health features of health systems through data from 194 countries and related law, scholarship, and health indicators. Accordingly, the authors proposed 72 right-to-health indicators, which could assist policy-makers in advancing more equitable and accountable domestic health policies.

Tools like right-to-health indicators ‘translate’ the legal norms of the right to health into tangible mechanisms with a range of benefits: They can guide policy-makers in realizing the right to health, guide judges in assessing whether states have complied with their duties, and provide civil society with measures and evidence to support advocacy and litigation. While right-to-health indicators like those developed by Backman et al. are relatively new, indicators have long been seen by the UN Committee on Economic, Social and Cultural Rights as capable of guiding states in the realization of their economic, social and cultural rights at the domestic level. Indeed, national and international tribunals and courts, as well as civil society, are using indicators to assess and monitor potential violations for a range of human rights [44].

(d) The right to health as a guide for global health policy

Reflecting its growing legal and political prominence, the right to health is regularly cited in global health policy documents across the domains from those in relation to non-communicable diseases to the social determinants of health [45, 1]. The right is prominent in particular in the move to formulate goals to replace the health-related Millennium Development Goals (MDGs), which expire in 2015, with global health institutions increasingly recognizing that this right provides key legal and ethical principles to guide the formulation of the Sustainable Development Goals [46, 47]. Moreover, many of the most significant reports issued through the post-2015 negotiation process frame their health goals in relation to this right. For example, the Global Thematic Consultation on Health’s April 2013 report uses the right to health to expressly frame its health goals, suggesting that since health is a human right, it should be prominent within post-2015 deliberations [48]. And the UN Open Working Group premises health’s centrality to sustainable development on the fact that “health is a right and a goal in its own right” [49].

These rhetorical references do not necessarily imply that the right to health is guiding the content of the health goals under consideration, however they do suggest that advancing health as an essential component of sustainable development is increasingly viewed as a fundamental human rights entitlement and duty. In addition, these references suggest that at least at a rhetorical level in these fora, the legal and moral force of the right to health is not being denied or refuted. These references reflect some level of political acceptance of the relevance of this right, and intimate the growing potential of this right to frame policy debates in a range of fora.

Conclusion

The right to health in international law has been extensively interpreted over the past several decades in ways that assist in 'decoding' its entitlements and duties for policy-makers, judges and civil society and offering increasingly tangible and powerful tools for advancing health. While these interpretations do not resolve all of the legal ambiguity attendant upon this right, they do provide a range of options for its realization, that actors at a variety of levels increasingly utilize effectively to advance health equity at the domestic and international levels. To this extent, the right to health is becoming an increasingly well-specified tool for those interested in advancing health equity. The analysis in this paper therefore accords with John Tobin's assessment that the right to health "holds immense promise as both a normative [...] and [...] operational framework," even as it continues to face legal, political, economic and cultural challenges [5]. Indeed, I contend that the social and legal variables identified in this paper can be instrumental in overcoming some of these challenges and thereby accessing a potentially powerful framework for advancing health equity globally.

Zusammenfassung

Die Bedeutung eines Rechts auf das Höchstmass an Gesundheit ist Gegenstand umfangreicher Diskussionen: Welche Ansprüche und Verpflichtungen genau begründet dieses Recht, sind diese Ansprüche und Pflichten einklagbar, und wären gerichtlich durchsetzbare Ansprüche hinderlich oder förderlich für die soziale Gerechtigkeit im Bereich Gesundheit? Um auf einige dieser Fragen zu antworten, bietet der Aufsatz einen Überblick über die rechtswissenschaftliche Herausbildung des Rechts auf Gesundheit im System internationaler Menschenrechtsnormen und analysiert seinen potentiellen Beitrag zum Erreichen gerechter Gesundheitsziele. Die Autorin stellt zunächst die Entwicklung des völkerrechtlichen Regelwerks dar, wel-

ches das Menschenrecht auf Gesundheit umschliesst. Anschliessend skizziert sie den Einfluss dieses Regelwerks auf die Verbesserung von sozialer Gesundheitsgerechtigkeit durch eine Vielzahl von Kanälen: vom Beschreiten innerstaatlicher Rechtswege, über die rechtsbasierte Ausrichtung von politischen Programmen, bis hin zur Formulierung von Gesundheitspolitik auf globaler Ebene, wie zum Beispiel im Rahmen der nachhaltigen Entwicklungsziele.

Résumé

La signification du droit de toute personne de jouir du meilleur état de santé physique et mentale qu'elle soit capable d'atteindre soulève de nombreuses questions: quels sont les droits et obligations attachés à ce droit? Est-ce que ces droits et obligations sont juridiquement contraignants? Est-ce que la nature contraignante de ces droits contribue à la réalisation de l'équité dans le domaine de la santé ou bien au contraire constitue un frein à cette réalisation? Cet article répond à certaines de ces questions en présentant l'évolution juridique et la construction du droit à la santé en droit international des droits de l'homme ainsi qu'en analysant la contribution de ce droit à la réalisation des buts d'équité dans le domaine de la santé. L'article présente notamment la contribution de cette approche en faveur de l'équité dans le domaine de la santé à travers l'analyse de son influence sur les décisions nationales de justice, sur les instruments politiques fondés sur les droits de l'homme ainsi que sur la définition des mécanismes de politique de santé globale à l'exemple des objectifs de développement durable.

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