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INHALT

Buchbesprechungen

Lisa Forman

Can Core Obligations under the Right to Health Achieve their Ambitions?[1]

1. Introduction

The last two decades has seen unprecedented advances in the interpretation and enforcement of the international human right to the highest attainable standard of physical and mental health ('the right to health'). This right is increasingly seen as capable of advancing equity in a variety of health domains, including medicines access, the social determinants of health and non-communicable disease (Forman 2008, United Nations 2011a, 2011b). Yet the legal formulation of this right remains troubled by its textual formulation in the *International Covenant of Economic, Social and Cultural Rights* (ICESCR), which limits state duties to progressively realize the highest attainable standard of health to the maximum of available resources (United Nations 1976, Art. 12 and Art 2.1). This limitation makes the provision of even essential health needs dependent on the availability of adequate resources, enabling governments to justify almost any extent of inaction (Chapman and Russell 2002: 5). To guard against this outcome, the Committee on Economic, Social and Cultural rights ('CESCR') has advanced the idea that states hold non-derogable „core obligations" to provide essential health services that are not subject to progressive realization within resources. Core obligations are intended to provide much needed scope and weight to essential right to health claims, by creating a baseline of legal protection for basic health services against governmental claims of scarcity, inadequate international assistance and competing private interests.. Yet, despite fairly broad uptake of core obligations in human rights practice and scholarship, the concept continues to be critiqued for conceptual vagueness and pragmatic unenforceability. A significant chasm persists between the ambition of the core concept and its formulation and application. Accordingly, in this paper I interrogate the utility of this concept in the following ways.

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First, by outlining the development and application of core obligations; second, exploring its key strengths and weaknesses; and finally, considering future pathways for the development and application of this concept.

2. The evolution of core obligations under the right to health

The aetiology of core obligations is rooted in the legal and historical development of the right to health in international law, and the twin challenges posed by vague treaty formulations and Cold War geopolitics that saw economic, social and cultural rights de-prioritized and underdeveloped in Western liberal democracies. The first international iteration of this right appears in the 1946 *Constitution of the World Health Organization*, which establishes that organization as a specialized agency of the newly established United Nations. The WHO Constitution recognizes 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", and defines health expansively as „a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (United Nations 1946, preamble). This expansive definition of health was not used in the 1948 *Universal Declaration on Human Rights* which rather than incorporating a free-standing right to health, recognizes every person's right to a standard of living adequate for their health and well-being which includes medical care (United Nations 1948, Art. 25). The most authoritative formulation of this right appears in the 1976 *International Covenant on Economic, Social and Cultural Rights*, where states recognized everyone's right to the enjoyment of the highest attainable standard of physical and mental health, and agree to take steps to achieve this, including reducing infant mortality, addressing infectious disease and assuring medical service to all in sickness (United Nations 1976, Art. 12). The ICESCR articulation of the right as being to the highest attainable standard of health picks up on the WHO Constitution's expansive definition of health (albeit without defining health as the latter instrument does). Yet this ambitious formulation is significantly undercut by article 2 of the ICESCR where states agree „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" (United Nations 1976, Article 2.1).

Certainly for states ratifying this treaty, there was little clarity on the scope and content of this circumscribed duty towards health, a task that required interpretation in subsequent human rights treaties and instruments (Forman 2013).

Since the ICESCR, the right to health has been explicitly extended to specific populations, including racial minorities, women, children, migrant workers, and people with disabilities (United Nations 1965, 1979, 1990, 2008). Moreover, rights to health are protected in each regional human rights system (Council of Europe 1961, Organization of African Unity 1986, Organization of American States, 1988), and in at least 115 domestic constitutions globally (Office of the High Commissioner for Human Rights and World Health Organization 2008: 10). Many of these treaties now hold almost universal ratification: For example, 195 states, an effective universality, are party to the Children's Rights Convention (CRC); 189 states have ratified the Convention on the Elimination of Discrimination Against Women (CEDAW); 177 have ratified the Convention on the Elimination of Racial Discrimination (CERD); and 164 have ratified the Covenant on Economic, Social, and Cultural Rights (CESCR) (United Nations Office of the High Commissioner for Human Rights 2015).

While these treaties have significantly expanded the legal force of the right to health, they have done little to resolve the dual dilemma created by limiting the expansive promise of a right to the highest attainable standard of health to progressive realization within resources. On the one hand, the highest attainable standard of health is a variable standard that shifts from country to country according to resource availability and health needs, leaving the right to health subject to critique as an aspirational rather than enforceable right (Goodman, 2005). On the other hand, progressive realization within resources could justify inaction on even the most basic of health needs, turning the right to health into the emptiest of promises.

In an effort to respond to precisely these kinds of dilemmas, the CESCR in 2000 issued a general comment on the right to health which extensively interprets the scope, content and duties arising from this right. Significantly, the CESCR emphasizes that rather than a right to be healthy, the right is an inclusive right to health care and the underlying determinants of health (such as food, housing, access to water and adequate sanitation, safe working conditions and a healthy environment) (United Nations 2000, para. 4). The Committee interprets progressive realization as requiring states to take immediate action and effective movement towards realizing this right, including by guaranteeing the non-discriminatory exercise of rights, and taking steps towards full realization, which are deliberate, concrete and targeted as clearly as possible towards meeting treaty obligations (United Nations 2000, para. 31). Further guidance on state

obligations is provided by the tripartite framework of duties to respect, protect and fulfil rights (United Nations 2000, para. 33), which impose a range of duties on states to realize rights in various contexts.

The CESCR presents as a central part of this interpretive framework the notion that the right to health, like other social rights, contains minimum essential levels not subject to progressive realization within resources. This concept draws textual support from the ICESCR itself, which indicates that its rights can only be limited insofar as is compatible with their nature, and that acts aimed at destroying these rights are not permitted (United Nations 1976, articles 4 and 5.1). The implication is that acts (or omissions) that effectively destroy realization of the right to health are impermissible. The CESCR's interpretation of core obligations into the right to health draws on earlier human rights scholarship and practice (Shue 1996, Örücü 1986, Andreassen 1987-1988), which was incorporated into successive international interpretations of economic, social and cultural rights. The non-binding 1986 *Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights* proposed that state parties are obligated to respect minimum subsistence rights for all regardless of their level of economic development (Limburg 1986, paras. 25 and 28). The 1997 *Maastricht Guidelines on Violations of Economic, Social and Cultural Rights* further developed this idea, suggesting that failures to satisfy minimum core obligations violated the ICESCR and that states had minimum core obligations irrespective of the national availability of resources or other factors or difficulties (Maastricht 1997, para. 9).

The CESCR incorporated the idea of the core into its interpretation of state obligations under article 2.1 in the 1991 General Comment 3, stating that

> *a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party. Thus, for example, a State party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education is, prima facie, failing to discharge its obligations under the Covenant. If the Covenant were to be read in such a way as not to establish such a minimum core obligation, it would be largely deprived of its raison d'être (United Nations, 1991, para. 10).*

On the question of how this duty aligned with resource constraints, the Committee indicates that to be able to attribute a failure to meet minimum core obligations to a lack of available resources, a state „must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations" (United Nations 1991, para. 10).

In General Comment 14, the CESCR explicitly defined core obligations under the right to health, at the same time as introducing the related idea of essential elements to the right to health that states hold irrespective of development levels. These essential elements (colloquially known as the AAAQ framework to reflect the first letter of each element) include public health and health care facilities goods and services (including hospitals, clinics, personnel and essential drugs) which are: Available in sufficient quantity and standards, Accessible to all physically, economically and without distinction, culturally and ethically Acceptable, and of good Quality (United Nations 2000, para. 12). The CESCR indicates that allied to these essential elements, states have core obligations that include at least: ensuring non-discriminatory access to health facilities, goods and services, especially for vulnerable or marginalized people; access to food, basic shelter, housing, sanitation and water; providing essential drugs as defined by WHO; ensuring equitable distribution of all health facilities, goods and services and adopting a national public health strategy and plan of action addressing the concerns of all (United Nations 2000, para. 43). In addition, states hold „obligations of comparable priority" to ensure reproductive, maternal and child health care, provide immunization against major infectious diseases, take measures to prevent, treat and control epidemic and endemic diseases, provide education and access to information on the main health problems in the community, and provide appropriate training for health personnel (United Nations 2000, para. 44). In General Comment 14, the CESCR posits a very high standard of compliance with core obligations, indicating that „a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations … which are non-derogable" (United Nations 2000, para. 47). This position is in stark contrast to the CESCR's interpretation in General Comment 3 that a state could justify non-compliance with minimum core obligations by demonstrating every effort to use all resources available to satisfy these obligations as a matter of priority.

The CESCR has defined core obligations under multiple other Covenant rights, including rights to education, water, work, and social security (United Nations 1999, 2002, 2005, 2007). Other UN treaty bodies have adopted the concept: The Children's Rights Committee ('CRC') has defined core obligations under children's right to health in its 2013 General Comment 15 on the Rights of the Child to the Enjoyment of the Highest Attainable Standard of Health (UN CRC, 2013). The CRC defines core obligations under children's right to health to include:

> *(a) reviewing national and subnational legal and policy environment and, where necessary, amending laws and policies; (b) ensuring universal coverage of quality primary health services, including prevention, health promotion, care and treatment services, and essential drugs;*

> *(c) providing an adequate response to the underlying determinants of children's health; and (d) developing, implementing, monitoring and evaluating policies and budgeted plans of actions that constitute a human rights-based approach to fulfilling children's right to health (UN CRC 2013, para.73).*

While this definition closely follows that posited in general comment 14, the explicit identification of universal coverage of primary health care services goes beyond General Comment 14's terser definition which only identifies essential drugs. The United Nations Committee on the Elimination of Discrimination against Women ('CEDAW') has similarly adopted the concept, identifying non-discrimination as a core obligation under the *International Covenant on the Elimination of Discrimination against Women,* which states hold an „immediate and continuous obligation to condemn" (CEDAW 2010, para. 15). In a 2011 decision on an individual complaint, CEDAW found Brazil in violation of this duty for failing to assure appropriate maternal health services (CEDAW 2011, para. 7.6).

The concept has similarly been incorporated into domestic enforcement of rights in several Latin American countries. The Colombian Constitutional Court has concluded that health care is a basic right with a minimum core that can be independently enforced without having to rely on concurrent right to life claims (Lamprea 2013). Core obligations under the right to health have also motivated policy reform of the public health care system (Lamprea et al., forthcoming). The Costa Rican Supreme Court has in successive decisions utilized the minimum core of the right to health to define core state obligations, which it has interpreted to include life-saving treatment for people with HIV/AIDS (Costa Rican Supreme Court 1997, 2007, 2009) The Indian Supreme Court has not directly cited the minimum core concept, however considerations of „the essential minimum" and „what is minimally required" have been primary in claims for emergency medical care and minimum levels of food (Indian Supreme Court 1996, 2001). In contrast and as discussed in greater detail below, the South African Constitutional Court has rejected the domestic application of core obligations despite an enforceable constitutional right to access health care services (*Constitution* 1996, section 27).

3. The Strengths and Weaknesses of the Core Concept

The normative priority of essential health needs advanced by core obligations could influence the weight accorded to such claims when courts are called upon to adjudicate denials of basic health needs against governmental claims of scarcity or competing private

interests. In addition, the core obligations concept locates domestic and collective action to realize essential health services within a legally binding framework with some enforceability and sometimes considerable normative and political influence (Forman et al. 2013). Thus the core could alter the judicial burden of proof required to establish resource constraints as justifiable reasons to withhold basic health needs, requiring at a minimum that such deprivations be held to very strict scrutiny. If core obligations were viewed in this way, judges might be less willing to accept state allegations of resource constraints without rigorous evidential support (Forman 2009). In addition, core obligations could guide policy-makers in creating and implementing more equitable health policy and empower civil society to claim their essential health needs from both domestic and global policy makers and courts (Forman et al. 2013). Moreover, they might influence policies outside of health that cause deprivation: For example, viewing essential medicines as a minimum core obligation could influence how intellectual property rights under the World Trade Organization's Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) are formulated, implemented and interpreted, given how extensively TRIPS may limit medicines access for the poor (Forman 2009).

Despite this normative potential and fairly broad uptake, the concept is subject to heavy scholarly and judicial critique. Of particular concern is its rejection by the South African Constitutional Court, one of the only common law courts globally to enforce social and economic rights like health. In *Government of the Republic of South Africa & Others v. Irene Grootboom & Others* (2000), the Court rejected amicus curiae's submissions that it should recognize a minimum core, arguing that it lacked the competence or information necessary to do so (Grootboom 2000, paras. 27-33). In its place, the Court posited a constitutional standard of reasonableness for adjudicating the Constitution's social and economic rights, summed up as a duty to act reasonably to provide the basic necessities of life to those who lacked them (Grootboom 2000, para. 24). In contrast to the specified components of the minimum core approach, a reasonableness approach is more procedurally focused on comprehensive programs aimed at meeting short, medium and long term needs, albeit that these must be explicitly focused on meeting the needs of the poor and on meeting urgent needs (Grootboom 2000 paras. 35-44). In addition, rather than following the CESCR's designation of core obligations as nonderogable, the reasonableness approach does not require a state to do more than available resources permit, so that resources would determine the content and pace of realization, albeit that government should nonetheless give adequate budgetary support to social rights and plan and monitor efforts to meet all needs (Grootboom 2000, para. 32, 68).

The South African Constitutional Court confirmed this approach in its 2002 decision of *Minister of Health & and Another v. Treatment Action Campaign & Others,* arguing that it was 'impossible to give everyone access even to a „core" service immediately' and that '[a]ll that is possible, and all that can expected of the state, is that it act reasonably to provide access to the [Constitution's socio-economic rights] on a progressive basis" (Minister of Health 2002, para. 35). The Court argued that doing more than this would breach the appropriate separation of powers and extend beyond the „restrained and focused" judicial role contemplated by the Constitution (Minister of Health 2002, para. 38). The South African Court's rejection of this concept is a heavy blow given the court's global stature in the interpretation and enforcement of human rights, and especially social and economic rights.

The core concept has also been extensively critiqued in human rights scholarship. Katherine Young argues that given limited judicial and CESCR competence to define and enforce the core, human rights law should move away from defining minimum bundles of commodities or entitlements towards one that instead „establishes processes of value-based, deliberative problem-solving" (Young 2012: 6). Young argues that the normative ambitions of the core should instead be transferred to other areas of rights like benchmarks and indicators and assessments of causality and responsibility (Young 2008: 117-118). John Tobin argues that the Committee's definition of the core is unjustified and impractical, and argues for a „modest and practical" vision of the core of the right to health given resource constraints and the need for nationally variable lists of core obligations (Tobin 2012: 243-247). Danie Brand sees the core as suitable only for the international enforcement of social and economic rights, whereas the domestic enforcement of such rights requires „far more specific, particular, concrete, context-sensitive and flexible … thinking about basic standards, core entitlements and minimum obligations" (Brand 2002: 99-110). While in general support of the concept, Audrey Chapman and Sage Russell caution against the risk that the core concept could erode the scope of the right to health, becoming a ceiling rather than a floor for health action (Chapman and Russell 2002).

Even supporters of the concept like myself, acknowledge its conceptual limitations. Previous scholarship identified several key deficiencies in the Committee's interpretation of core obligations under the right to health (Forman et al. 2013). First, the Committee's interpretation provides little clarity on which health services, facilities and services fall within the minimum core beyond essential medicines and underlying determinants such as food, basic shelter, housing, sanitation and water. Second, the relationship between „obligations of comparable priority" and core obligations is

unclear, raising questions about how courts and policy-makers should approach these sets of duties. Third, there is no explicit identification of international core obligations, with potentially corrosive impacts on the realization of minimum core obligations in low and middle-income countries. Fourth, the Committee fails to address the key question of the resources necessary to meet minimum core obligations beyond emphasizing that core obligations are non-derogable and that states cannot justify non-compliance with these obligations under any circumstances, including by implication, due to resource constraints. The strong articulation of core obligations as non-derogable appears to place financially unrealistic obligations on poorer countries to meet core obligations (Forman et al. 2013). Fifth, it is unclear if core obligations are intended to provide a universal standard or whether they should defined for each national setting. This dilemma raises questions of whether core obligations should be set at a high aspirational level with the tacit acknowledgement that most countries will lack the ability to immediately realize them or at a more modest level that provides a more realistic set of immediate obligations (Forman et al. 2013).

4. What pathways forward for the core?

If the core is to achieve its normative ambitions, we argued that these weaknesses should be remedied through the legal, political and social development of core obligations under the right to health. We argued that first, such developments could incorporate exploration of how this concept is being judicially interpreted and applied around the world in order to clarify if a judicial consensus regarding this concept exists (Forman et al. 2013). Such a consensus would provide authoritative support for the legitimacy and development of this right in accordance with established rules of international law. Second, exploring the use of analogous concepts by governments in defining essential health benefits packages in the public sector could provide an indication of what low and middle income countries states consider practically feasible and necessary in relation to local context. Third, there would be significant value in assessing how this concept accords with community expectations and lived experience around essential health needs (Forman et al. 2013). Fourth, international global health policy could indicate an international consensus of sorts regarding essential health needs and priorities. These sources provide one avenue for further developing core obligations under the right to health, by combining extant consensus on state duties towards essential health needs with aspirational domestic and global health goals that seek to advance health equity.

Certainly a key test of the concept will arise in the CESCR's own interpretations as it begins to adjudicate individual complaints under the newly operational *Optional Protocol to the International Covenant on Economic, Social and Cultural Rights* (United Nations, 2008b). The Optional Protocol provides a watershed moment for the international enforcement of economic, social and cultural rights by enabling individuals in ratifying countries to seek redress from the CESCR. It is therefore of great significance that the CESCR has indicated that in its examination of communications, it

> *shall consider the reasonableness of the steps taken by the State Party in accordance with part II of the Covenant. In doing so, the Committee shall bear in mind that the State Party may adopt a range of possible policy measures for the implementation of the rights set forth in the Covenant (United Nations 2008b, article 8.4).*

A drafter of the Optional Protocol has confirmed that the language of 'reasonableness' is deliberately taken from the South African Constitutional Court's decision in Grootboom (de Albuquerque 2010: 175). This incorporation raises cogent questions about how the Committee will square the South African Constitutional Court's rejection of core obligations with a reasonableness-based assessment of state compliance with Covenant duties. Certainly it seems unlikely that the Committee will reject a concept it has developed and incorporated so extensively into its own interpretative jurisprudence. Yet the apparent disjuncture between the core obligations approach and the reasonableness standard poses challenges for the Committee as it embarks on the direct enforcement of Covenant rights. Will it replace the non-derogable nature of core obligations with a more process-oriented focus on reasonable measures that takes account of resource constraints? Or will it incorporate substantive core obligations under the right to health into its assessment of state compliance with Covenant duties? The Committee's willingness to enforce core obligations under the right to health will assuredly put this concept to the test.

5. Conclusion

The core concept holds the potential to advance the priority of essential health needs in domestic and international health policy, programming and adjudication. Yet to reach this potential, the current formulation of the core needs to respond to some of its key weaknesses identified in this paper. If these conceptual deficits can be resolved, core obligations could solidify and expand the significant gains made in the interpretation and enforcement of the right to health over the last decades. There could be no

greater indicator of the future of core obligations than in the Committee's adjudication of Optional Protocol communications. How the Committee proceeds in this regard will illustrate whether the core concept has reached the limits of its normative utility or whether it can in fact enable the aspirational promise of health justice and equity at the heart of the right to health.

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ABSTRACTS

Michael Krennerich: Das Menschenrecht auf Gesundheit

Der Beitrag legt die völkerrechtlichen Grundlagen des Menschenrechts auf Gesundheit dar. Es beschreibt die inhaltlichen Grundzüge dieses Rechts auf und zeigt anhand konkreter Beispiele auf, welche Achtungs-, Schutz- und Gewährleistungspflichten sich daraus für die Staaten ergeben. Aus Sicht des Autors ist menschenrechtliches Empowerment unabdingbar, damit die Betroffenen ihre menschenrechtlichen Ansprüche gegen Widerstände auf juristischem und politischem Wege zur Geltung bringen – und das Menschenrecht auf Gesundheit Wirkung entfaltet.

The human right to health

The article lays out the international legal foundations in regard to the right to health. It presents the general idea of this right and explains based on concrete examples which state responsibilities it implies, in particular responsibilities to respect, protect and fulil. The author claims that the realization of the human right to health requires that humans are empowered to claim the right even against strong resistance, in particular through legal and political means.

Lisa Forman: Can Core Obligations under the Right to Health Achieve their Ambitions?

Despite significant advances in the interpretation and enforcement of the right to health, the limitation of state duties under this right to progressive realization to the maximum of available resources enables governments to justify almost any extent of inaction on health. To guard against this outcome, the Committee on Economic, Social and Cultural rights ('CESCR') has advanced the idea that states hold non-derogable „core obligations" to provide essential health services that are not subject to progressive realization within resources. Yet, despite fairly broad uptake of core obligations in human rights practice and scholarship, a significant chasm persists between the ambition of the core concept and its formulation and application. Accordingly, this paper interrogates the utility of this concept by outlining the development and application of core obligations, exploring its key strengths and weaknesses, and considering future pathways for the development and application of this concept.

Können Kernpflichten bezüglich des Rechts auf Gesundheit durchgesetzt werden?

Trotz bedeutender Fortschritte bezüglich der Interpretation und Umsetzung des Rechts auf Gesundheit ist die staatliche Pflicht nicht absolut, sondern konzipiert als eine Pflicht der progressiven Realisierung im Rahmen der zur Verfügung stehenden Ressourcen. Dieses Konzept erlaubt es Regierungen, beinahe jedes Niveau von Untätigkeit zu rechtfertigen. Um dagegen vorzugehen, hat der UN-Ausschuss zu wirtschaftlichen, sozialen und kulturellen Rechten (CESCR) die Idee entwickelt, dass Staaten Kernverpflichtungen in Bezug auf Gesundheit haben, insbesondere die Bereitstellung einer Grundversorgung, die nicht von zur Verfügung stehenden Ressourcen abhängig gemacht werden kann. Obwohl der Idee der „core obligations" von AkademikerInnen und PraktikerInnen viel Aufmerksamkeit geschenkt wird, besteht eine Lücke zwischen dem Anspruch und der konkreten Ausformulierung. Dieser Artikel diskutiert den Nutzen des Konzeptes. Die Autorin erläutert die Genese der Idee der Kernverpflichtungen, weist auf zentrale Stärken und Schwächen hin und zeigt zukünftige Entwicklungs- und Anwendungsmöglichkeiten auf.

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