

Global Health and Human Rights

Legal and philosophical perspectives

Edited by
**John Harrington and
Maria Stuttaford**



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1 Introduction

John Harrington and Maria Stuttaford

1 Themes

In the last decade, the human right to health has moved to the centre of political debate and social policy across the globe. Civil society organizations have put this right at the heart of campaigns for health justice at national and global levels. It features prominently in the output of the United Nations (UN) and regional human rights bodies, as well as national courts and legislatures; national constitutions increasingly include explicit recognition of the right to health. Long neglected in the legal academy, many scholars now labour to develop its normative content, to contextualize its application and to evaluate it from the point of view of moral philosophy and theories of justice. This has been a remarkable transformation.

The right to health has certainly been a feature of international human rights law since the Second World War. The Universal Declaration of Human Rights (1948) states 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’ (Art 25.1). The Preamble to the Constitution of the World Health Organization (WHO 1948) contains a similar affirmation. These principles were given legal force in the International Covenant on Economic, Social and Cultural Rights (ICESCR) (1966).¹ In Art 12.1 ICESCR States Parties ‘recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’. The right is similarly recognized in Art 5(e)(iv) of the Convention on the Elimination of All Forms of Racial Discrimination (1965), Arts 11.1(f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women (1979) and Art 24 Convention on the Rights of the Child (1989). However, notwithstanding this pedigree, the right to health was relegated to secondary status as a social and economic right for much of the postwar period; it was fatally identified with Soviet ideology during the Cold War. Widespread political hostility was underpinned by juristic and philosophical scepticism. For many, the very idea of a right to health suffered from vagueness, incoherence and incompleteness, especially when compared with more established civil and political rights (see Evans 2002). How could States guarantee to make everyone healthy? How could any limit be

set to this obligation? What of other State priorities? Scarcity of resources was inevitable and could not be wished away by fine-sounding principles. As a result, the right played little positive role in the creation of welfare States in Europe and North America or in the endeavours of the developmental State in Africa, Asia and Latin America.

Ironically, the fortunes of the right to health have been transformed in the period after the end of the Cold War, just as State socialism was overwhelmed by a reinvigorated, globalizing capitalist system. The right seems to have been freed from the stigma of association with the Eastern Bloc. At the same time, it has gained in relevance as a response to the collective and individual trauma caused by a drastic reduction of social guarantees in many countries (MacDonald 2005). Moreover, multiple health catastrophes in the developing world – some relatively new, like HIV/AIDS, some of long standing like tuberculosis, diarrhoea and malaria – have at last called forth the concern and engagement of lawmakers, activists and professionals (Thomas and Weber 2004). The right to health has been deployed to give normative force to claims for access to essential medicines and for international solidarity in combating disease (Sell 2002).

These political changes have been supported by a number of important legal developments. In 2000, the UN Committee on Economic, Social and Cultural Rights (CESCR) published General Comment 14, an extensive and authoritative interpretation of Art 12 ICESCR. This work of elaboration and application was continued from 2002 with the appointment of Professor Paul Hunt as UN Special Rapporteur on the Right of Everyone to the Highest Attainable Standard of Health (Commission on Human Rights 2002). Most recently, in December 2008, the UN General Assembly adopted an Optional Protocol to the ICESCR allowing individuals and groups to bring complaints against States for violations of the right to health, among other social and economic rights (UN 2008). The first-hand experiences of the Special Rapporteur are considered in the third chapter of this volume. The Optional Protocol has yet to come into force, so its effects remain to be seen. We turn, therefore, to the path-breaking normative implications of General Comment 14. This develops the specific implications of the right to health as a social and economic right of progressive realization. The latter attribute does not mean that the right is emptied of ‘all meaningful content’ (CESCR 2000: para 31). On the contrary, it implies a ‘specific, continuing obligation to move as expeditiously and effectively as possible towards the full realization of Article 12’ (CESCR 2000: para 31). Detailed and regularly monitored targets are essential to this process. Moreover, although it is unfolding over time, the implementation of the right demands that certain essential steps are taken immediately. Most significant of these is the requirement that States adopt and implement a national health strategy addressing the needs of the whole population with regard to health care provision and the underlying determinants of health (CESCR 2000: para 43). A planned, systemic approach to health is thus a requirement of international human rights law. General Comment 14 goes on to state that ‘gross inequality in health status, particularly between developed and developing countries, as well as within countries, is politically, socially and

economically unacceptable' (CESCR 2000: para 38). No longer a matter of fate, health injustices must be specifically tackled.

The terms of General Comment 14 mean that the right to health cannot be reduced to a bare mechanism for reallocating resources to (or within) the health budget, vitally important as this is. It is not merely a vehicle for individual litigation in pursuit of private advantage (although this is not without significance in its implementation). Rather, as the essays in this collection demonstrate, the right to health has a powerful and wide-ranging contribution to make to law, politics and policy-making. This contribution registers in three important and interrelated ways: cognitive, archaeological and critical. The cognitive gain from the right to health arises from its coupling of law with diverse health knowledges (Bauch 1996; Harrington 1999). As has been suggested above Art 12 ICESCR is an open-textured norm. Its core term ('the highest attainable standard of physical and mental health') cannot be adequately defined within the self-referential terms of legal argument. Rather, the right can only gain significant content through specific standards and measures developed by health practitioners, and with the input of ordinary citizens. It is, of course, true that law and biomedicine have long been linked in this way. The application of coercive mental health legislation, for example, often depends on the opinion of one or more psychiatrists (Keywood 2003). But such cognitive openings of the law to medicine are generally quite narrowly circumscribed. The scope of Art 12 is, by contrast, much greater. As General Comment 14 states, it entails an immediate obligation to commence planning for an integrated health care system and for measures to secure the non-medical, underlying determinants of health (CESCR 2000: para 30). To this extent, the meaning of the core term is produced by the interaction of a variety of disciplines in and around public health.

The coupling of law and public health in Art 12 facilitates a kind of parallel processing, whereby measures and proposals are simultaneously subject to evaluations within each system (Luhmann 1997: 776–788). Thus, data showing health disparities as between men and women, say, register as a matter of concern within public health science. For that reason, they simultaneously constitute evidence of a violation of Art 12 (see CESCR 2000: para 57). The effect is to extend the reach of human rights law: a great deal more of the social world becomes subject to the application of legal standards; many more sources of injustice and inequality are brought to light and condemned. It also provides a normative challenge to health workers and administrators, imbuing much of their work with direct normative significance. Human rights law can thus provide an orientation to values beyond the interests of the profession and the profit-maximizing calculus of the market (Farmer 2005: 234).

The cognitive gain extends beyond the disciplinary symbiosis of law and public health. As several contributors to this volume note, the right to health includes strong obligations on States to ensure transparency, participation and accountability. These requirements, it can be argued, do not merely follow on from a predefined right to health; they are not simply the legal manifestation of a 'top-down' regime of consumer surveys and formulaic consultation procedures.

Rather, by enabling popular participation in the definition of health needs and in the development of health policy, they contribute reflexively to the process of defining the right itself (see Teubner 1990: 27). This process is ongoing. The political opening up through the right to health thus represents a distinctive gain in knowledge and information, as the users and potential users of health services actively participate in shaping their own prospects (CESCR 2000: para 53). In other words, by virtue of its inherent openness, the right to health facilitates its own self-transformation and, thereby, the open-ended transformation of society.

The archaeological potential of the right to health is realized through a retrieval of formerly suppressed knowledges relating to human welfare. Action to improve health has long been dominated by a rigidly biomedical model, which privileges clinical care over more wide-ranging interventions (McKeown 1976). This model strongly promoted the monopolistic ambitions of the medical profession. Alternative therapy and lay healing practices were marginalized and subordinated to medicine by legislative fiat. Curative medicine has also proven to be a fertile sphere of accumulation for commercial interests (Leys 2001). Its key features – drugs, equipment and clinical services – are produced as discrete, saleable commodities. These absorb much the greater part of public and private spending on health across the globe. By contrast, as has been noted, the ‘inclusive’ right to health requires policy-makers to move beyond narrow vertical interventions aimed at specific diseases and to address the underlying determinants of ill health (CESCR 2000: para 4). This holistic approach revives the nineteenth-century tradition of social medicine associated with Rudolf Virchow, which was directed at the underlying economic and environmental causes of human morbidity (see Göckenjan 1985). It draws equally upon the primary health care movement of the 1970s, associated with the World Health Organization’s Declaration of Alma Ata (WHO 1978). The latter also promoted a holistic approach and put community participation, in developing countries and elsewhere, at the heart of health improvement strategies.

The critical potential of the right to health lies in its capacity to open up formerly closed areas of thought and discourse regarding health improvement and access to care. Traditional limits to debate over health are set by common sense assumptions regarding necessary constraints: the finitude of resources for health; the biological origins of disease; the inevitability of tragic choices in allocation and so on. As a result, many obstacles to better health have been naturalized in policy discourse and in law (see Baxi 2002: 24–41) – they are a matter of fate, about which little can be done directly. Vast health inequalities between different parts of the world, or between different groups within the same country, are thus naturalized. The negative health consequences of State policies (e.g. for development and industrialization) and private industry (e.g. by pollution and poor working conditions) are similarly rendered as mere externalities, as matters of fate. This regime of common sense underpins a globally unjust allocation of health benefits and burdens. It effaces individual and institutional responsibility and throws the disadvantaged upon the mercy of public and private philanthropy (see Pogge 2002). Moreover, responses to health problems are contained within a

framework of binary oppositions: the market and the State; political freedoms and social entitlements; acts causing ill health and failures to prevent ill health. Health-promoting interventions are relegated to the subordinate pole of each of these binaries. Thus: regulating the marketing of breast milk substitutes amounts to State intervention in the 'normal' workings of the market; democracy requires a free press, but not freedom from hunger; tort law offers redress for positive harm, but not for failure to render aid (see Ruger 2006).

The human right to health challenges the 'taken-for-granted' status of these assumptions and oppositions. It does this through its detailed normative engagement with all areas of social life relevant to health, and in particular its close coupling with lay knowledges and the broad range of health sciences, as discussed above. Full elaboration of the right demands the generation of information regarding the many social causes of ill health (CESCR 2000: paras 13, 30). It presumes that these are susceptible to positive intervention at a collective level and it requires such interventions in discharge of States' human rights obligations. Each increase in knowledge mandated by the right to health, each detailed policy recommendation, each conceptual refinement of the right itself, opens up a space for critical debate over the terms of justice and solidarity. The right thus demystifies the existing rhetorical and practical limits to health improvement. This may surprise hostile commentators who see the right as no more than a slogan, empty and abstract.

These themes are raised in various ways by the different contributions to this book. Some focus on the broad scope of the right to health and its grounding, or lack of grounding, in a shared conception of justice. Others address specific, concrete topics in health policy, unfolding the implications of the right in those areas. Several engage with the historical development and current relevance of the right within the broader political conjuncture. The definition and uses of the right to health in different fora are considered: courts, legislatures, public administration and civil society organizations. Of course, we cannot distil a single substantive message from the rich diversity of thought pursued in these essays. The overriding insight is perhaps more abstract, concerning the increasingly detailed normative understanding of the right to health, its growing prominence within legal and non-legal discourses and its centrality to social and political reform. All chapters show that we have moved beyond the period of defensiveness, when most discussion on the right to health was detained by the existential question of whether it could ever exist in the first place. A beginning has been made.

2 Chapters

In the first chapter **Upendra Baxi** reflects on the relevance of justice to understanding and implementing the human right to health. He highlights the profound importance of health as a prerequisite to the enjoyment of all other rights. The right to health must be conceived in equally wide-ranging terms, as regards both its scope and the addressees of obligations arising under it. However, current debates on global health are constrained by a pragmatic focus on what is feasible

within given limits. In the present conjuncture, justice is neither expedient nor fashionable. Consequently, the right has been elaborated in the relatively confined and instrumental terms of international policy discourses, such as the Millennium Development Goals. As exemplified in General Comment 14 and in the reports of the Special Rapporteur, these have certainly helped to fill out the normative content of the right to health. However, Baxi argues, much critical force is lost in the absence of an animating theory (or theories) of health care justice. Health care justice offers a distinctive idiom in which to challenge the accepted limits to the enjoyment of the right to health. Scarcity of resources, civil and international wars, the history of conquest and colonialism and unequal economic development are all ‘man-made’ causes of ill-health. Relational justice demands that we identify the perpetrators, as well as the victims, in these cases. A parallel conception of reparative justice requires us to trace responsibility for violations over national frontiers and across the generations, beyond the realm of the State and into the private sector. Baxi concedes that languages of justice are commonly indeterminate and subject to contestation. But this represents more of an opportunity than a shortcoming, in so far as it exposes questions of distribution and fairness to the widest possible scrutiny and debate. The ongoing challenge to the World Trade Organization’s global patent regime is an outstanding example of the creative potential of justice-based arguments and activism. On the one hand, significant, if incomplete, progress has been made in extending access to essential medicines in the most impoverished nations. On the other hand, the hegemony of trade and profit has been disrupted and the closed fora of international trade diplomacy opened up to non-commercial voices.

In their chapter, **Paul Hunt** and **Sheldon Leader** reflect on the experiences of the former as United Nations Special Rapporteur on the Right of Everyone to the Highest Attainable Standard of Health between 2002 and 2008. Through a wide variety of studies concerning specific health themes, as well as country reports, the Special Rapporteur worked to elaborate the normative content of Art 12 ICESCR and in particular to build upon General Comment 14 of the CESCR. Over the course of the mandate it became clear that, while health workers are central to realizing the right to health, they are often alienated by the abstract and legalistic terms in which the right is framed. The Special Rapporteur’s resulting engagement with medical and other professionals needs to be emulated by health lawyers and scholars. The very structure of Art 12 demands a close integration of legal standards and public health knowledge. States are required to formulate national health plans as a matter of immediate obligation. They must act on these plans, taking coordinated, concrete steps toward the progressive realization of the right. Benchmarks and indicators, as well as systems of impact assessment and quality control, are integral to this process. They also provide substance to the concomitant duties of transparency, participation and accountability. Hunt and Leader acknowledge the role of courts in clarifying the right to health and in vindicating individual rights, but they warn of the potential for litigation to skew health care allocations in favour of those with the readiest access to the legal system. They draw on this insight in responding to

Baxi's criticisms of the Special Rapporteur's emphasis on policy and planning. It may in fact be the latter approach that secures the greatest improvement in health for the worst off. Furthermore, they insist that many of the practical recommendations made during the mandate are clearly imbued with a spirit of justice, albeit implicitly. Institutional constraints must be acknowledged, however. The Special Rapporteur was required to build on positive international human rights law, which does not endorse any single theory of justice.

Lisa Forman considers the pioneering right to health jurisprudence of the South African Constitutional Court with reference to the concept of the 'minimum core' elaborated in General Comment 14. It is a chief virtue of the latter that, by developing a detailed taxonomy of normative obligations, it disrupts the reified distinction between positive and negative rights, so often deployed to thwart the legal claims of the poor and needy. Forman shows that there are positive and negative dimensions to both civil-political and social-economic rights. Moreover, State action in each dimension of either type of right may lead to very significant expenditure. In any case, as she notes, several important elements of the minimum core under Art 12 relate to planning, governance and accountability. These engage the democratic and deliberative functions of the State at least as much as the directly allocative tasks. In its well-known Treatment Action Campaign decision, the South African Court refused to test the HIV/AIDS policy of the South African government with reference to the minimum core standard, preferring instead a more 'procedural' reasonableness test. Many commentators were disappointed at this turn. However, Forman questions whether the decision really 'fractures the spirit and intent of international human rights law', particularly when the true import of the Court's reasoning and the practical outcome of the case are considered. For one thing, the refusal of the minimum core concept was strategic to a significant degree – calculated to show due deference to executive competence. In substance, the Court demanded that the government account for the fact that its health policies and resource allocation had been determined in wanton disregard for the most basic needs of the most impoverished and vulnerable in South African society. Viewed in this way, the Court's reasoning was certainly compatible with the internationally defined minimum core. It also kept faith with the transformative purpose of the Constitution in so far as it refused to treat the non-availability of resources for basic needs as a simple matter of fate. Under South African constitutional law, as much as under international human rights law, scarcity is removed from the naturalized realm of necessity and opened up to political, legal and moral debate. At the all-important level of practice, the government was forced to provide antiretroviral therapy for women and infants as well as the necessary facilities across the territory.

The last two decades have seen a huge increase in research outsourcing, with drug trials initiated and approved in developed countries, but conducted in resource-poor settings. To what extent are scientific investigators obliged to provide these low-cost 'bioworkers' with ancillary care (i.e. for conditions identified during the research, but unrelated to the trial itself)? **Roger Brownsword** grounds his response to this question in the notion of a 'shared moral community

of rights'. In such a community, agents take the essential interests of others as seriously as their own, and it is recognized that more than an absence of restraint is required for agency to flourish. As he suggests, this ethical standpoint will have purchase in legal regimes founded on human rights principles. He elaborates and applies a four-stage test to determine whether participants can have legitimate expectations of ancillary care, i.e. is the researcher in a position to assist; can she do so; is it reasonable to expect her to do so having regard to her own interests; and would it be fair having regard to the participant's own capacity and conduct. The positive obligation that Brownsword identifies on this basis is not diminished by the fact that foreign researchers and local trial subjects belong to different communities of rights. It is no less than the obligation owed to domestic participants in the UK's Biobank initiative, which he considers in parallel here. The ethical conclusion is unlikely to be reflected in English private law, however. Unlike a shared community of rights, the latter leans rather more towards an ethic of self-reliance, emphasizing negative rather than positive background obligations. Indeed, the prior approval system of ethics committees may prove a more reliable and effective means of securing moral obligations to provide ancillary care than *ex post* litigation.

In her chapter, **Brigit Toebes** demonstrates the power of a human rights framework in identifying and combating the threat to health posed by corruption. The open-textured nature of Art 12 ICESCR facilitates the integration of sociological and activist insights on the nature, causes and effects of corruption into legal analysis of this problem. Defining corruption as 'the misuse of entrusted power for private gain', Toebes illustrates its endemic nature and its pernicious consequences for the functioning of health systems and for human well-being in developing countries. Using the pattern of analysis laid down by the CESCR in General Comment 14, she is able to elaborate specific obligations and corresponding duty-holders. The latter category must be drawn widely given the role of foreign aid in much health care provision, as well as the worldwide commercialisation of medical practice and the central role of health professionals in the delivery of care. Furthermore, as Toebes demonstrates, concrete violations of the right to health can be specifically enumerated in this context, highlighting areas for immediate State action. The practice of medicine is marked by stark asymmetries, and health care systems are highly complex. Acts of corruption, such as bribery, always involve at least two parties, neither of whom will be interested in remedying the wrong. These features heighten the need for systemic measures against corruption, focused on planning, prevention, accountability and responsibility. The potential of the right to health in this area lies precisely in that fact that it provides detailed normative guidance in relation to these systemic issues to at least the same extent as it furnishes the individual citizen with subjective, litigable rights.

A further specific focus is provided by **Aoife Nolan** in her discussion of the right to health care of children as interpreted by domestic and international courts. This right is well anchored in international law, both in the ICESCR and in the Convention on the Rights of the Child. General Comments on both have

elaborated its content, emphasizing the special priority that States must give to protecting and promoting the health interests of children. Nolan identifies three underlying justifications for this: the physical susceptibility of children to diseases with drastic long-term consequences; the social vulnerability of children to discrimination that either proceeds from, or increases the risk of ill health; and the political exclusion of children from democratic decision-making on the distribution of resources for health. As Nolan shows, the international law right is increasingly reflected in national constitutional provisions. These vary greatly: some expressly protect the child's right to health, others do so by way of combining generic children's rights with a separate provision on the right to health, others again through the incorporation of the international covenants into domestic law. Some make the right directly justiciable, others include it among 'directive principles of social policy'. Nolan's survey of national case law reveals a similar diversity in judicial approaches to the nature of the State's obligation. This has been construed on the one hand as an immediate duty to meet the essential health needs of children (Argentina, Colombia) or on the other hand as an obligation to decide 'reasonably' on the allocation of resources taking particular account of the special position of children (South Africa). Nolan concludes that the developing child's right to health has promoted access to care, both in individual cases and through improved planning. However, she cautions that its enjoyment will depend, not just on constitutional texts, but also on the effectiveness of the court system, as well as a wide range of non-legal factors.

Benjamin Mason Meier draws on original archive research to chart the history of the World Health Organization's (WHO) involvement with the right to health. This is a tale of unfulfilled promise, as initial enthusiasm for a human rights approach has given way to a narrower, more technically defined mission. The Organization's 1946 Constitution defined 'health' broadly in terms of physical and social well-being, beyond the mere absence of disease. As in the Universal Declaration of Human Rights, enjoyment of the medical and social preconditions for health was characterized in the Constitution as a fundamental human right. A change of leadership in 1953 resulted in WHO abandoning its broad focus in favour of a strongly biomedical orientation to discrete health problems. The aim of this 'medicalization' was to avoid politicizing the work of WHO in the intensely polarized climate of the early Cold War. Its consequence was that WHO played no role in the legal codification of the right to health in Art 12 ICESCR. As a result, the normative content of the latter was vague as to the underlying determinants of health. Moreover, unlike other UN agencies in their respective fields, WHO refused to contribute to the enforcement of Art 12 through monitoring and reporting mechanisms. The lack of a legal basis for comprehensive public health strategies was to prove a significant obstacle to WHO when it resumed its interest in social medicine in the mid-1970s. The 'Health for All' strategy embodied in the 1978 Declaration of Alma-Ata was expressly based on an inclusive understanding of the right to health. Politically controversial and lacking a normative anchor of sufficient weight, however, the strategy foundered. In the 1980s, vertical and targeted programmes returned to favour, seen as more in