

The Human Right to Health: Conceptual Foundations

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Introduction

Health is a fundamental human right, indispensable for the exercise of many other human rights, and necessary for living a life in dignity. The right to the highest attainable standard of health as a normative standard was first enunciated in 1946 in the Constitution of the World Health Organization (WHO), and has since been reiterated in a number of WHO declarations, foremost amongst them the 1978 Alma-Ata Declaration on Primary Health Care and the 1998 World Health Declaration. But of course there were precedents. Prior to the eighteenth century, responsibility in case of disease or illness predominantly fell into the hands of private entities, such as churches and charities. State institutions usually only intervened in cases of epidemic or pandemic diseases, mostly laying down forms of quarantines. At the centre of all these mostly communal health considerations were efforts to provide adequate sanitation, particularly in the larger cities.¹ In the 18th century, awareness of public health and its importance for society grew rapidly, yet the concept of modern public health only developed in the days of the industrial revolution, when unhealthy working and living conditions, caused to a large extent by mass production, led to epidemics and other grave health problems, epitomized in the novels by Charles Dickens.

The spread of epidemics beyond national borders soon elevated these questions to the international level, as they were considered as threats to international trade, and were therefore discussed at the first international conferences on sanitation. In 1903, one of these conferences set up the

Office International d'Hygiène Publique (OIHP) which was later associated to the League of Nations, and ultimately became the Health Organization of the League of Nations. The concept of primary health care for all was first discussed at a conference convened by this new organization and was later taken up by the United Nations.

Work-related issues of health were also taken up in the International Labour Organization (ILO), founded in 1919. During the Second World War, the ideas of social rights and, in particular, health as a human right, were further developed and institutionalized. A milestone in that respect was Franklin D. Roosevelt's Four Freedoms speech in 1941, in which he proclaimed the crucial importance of the freedom from want. At the United Nations (UN) Conference on International Organization in San Francisco in 1945, this issue was taken up, and was later reflected in Article 55 of the UN Charter, and elaborated in the World Health Organization as a specialized agency of the UN. The right to health has been subsequently firmly established in numerous instruments at the international, regional and national levels.

The UN Charter-based protection

Under the so-called UN Charter-based system of human rights protection, Article 55 of the UN Charter says that "... the United Nations shall promote: a. higher standards of living, ... b. solutions of international economic, social health, and related problems ..., and c. universal respect for, and observance of human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion." Health is also referred to in Articles 57 and 62 of the UN Charter, as one of the fields of responsibility of the Economic and Social Council (ECOSOC). The most influential and basic document in this respect is, however, the Universal Declaration of Human Rights of 1948 (UDHR), which, when adopted by the UN General Assembly, was initially legally non-binding in nature, but has since assumed the status of customary international law for most of its provisions, affirming in Article 25(1) that "everyone has the right to a standard of living adequate for the health of himself and his family, including food, clothing, housing and medical care, and necessary social services".

The right to health set out in Article 25 of the UDHR has been the subject of work by the UN Human Rights Council, the former UN Commission on Human Rights, and the human rights special procedures. In particular,

a Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health was appointed by the Commission on Human Rights in April 2002.² Since the creation of this mandate, the Special Rapporteur has submitted annual thematic reports and reports on country missions to the Human Rights Council (and the former Commission). The members of the Human Rights Council and its predecessor body have also adopted a number of resolutions on the right to health, for example resolutions on human rights and HIV/AIDS³ (and endorsement of the International Guidelines on HIV/AIDS and Human Rights⁴), and on access to medication in the context of HIV/AIDS.⁵

The WHO, like most specialized agencies of the UN system, places great emphasis in its work on formulating policies, strategies and programmes of action, rather than laws. The primarily policy-oriented approach adopted by the WHO has nevertheless proved to be very successful. Member States of the WHO have followed the policies, programmes and recommendations elaborated since 1948, have contributed to the eradication or near-eradication of many diseases, and have helped to combat major pandemics and endemic diseases. The treaty approach has, by contrast, been utilized by the ILO in relation to workers' rights. The tripartite structure of that organization favoured such a legal approach. The organization's awareness of health problems is exemplified in Conventions No. 155 on Occupational Safety and Health (1981), No. 161 on Occupational Health Services (1985), and No. 169, the Indigenous and Tribal Peoples Convention (1989). The latter considers equal but culturally sensitive health care and protection an important factor with respect to indigenous peoples' labour rights.

Specifically, Article 3(d) of ILO Convention No. 182 against worst forms of child labour deems children's health as an essential criterion for the definition of the term "worst forms of child labour". It must be noted that the ILO Conventions are legally binding documents for those states that are parties to them, and in such cases apply immediately to states, labour unions and employer organizations.

Under the UN Charter-based system, various declarations have been elaborated, dealing with health matters, such as the Vienna Declaration and Programme of Action of 1993, alluding to the right to health in several of its paragraphs, acknowledging, in particular, the importance of health care and protection.

The UN Millennium Declaration of 8 December 2000, adopted by the UN General Assembly, also stresses the importance of health care and

prevention of disease by committing states to the improvement of maternal and child health, and the combat against HIV/AIDS, malaria, and other major diseases. Of the eight UN Development Goals (MDGs), three have a direct healthcare dimension (goals 4, 5 and 6), while target 17 of MDG No. 8 calls for cooperation with pharmaceutical companies, in order to provide access to affordable essential drugs in developing countries. By way of example only, let us refer here to a number of texts that elaborate health issues: the Standard Minimum Rules for the Treatment of Prisoners (1977), as well as the Basic Principles for the Treatment of Prisoners (1990), include many references to health care and protection; or the UN Principles for Older Persons (1991) stress the importance of access to adequate health care facilities “to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness”; or the UN Principles for the protection of persons with mental illness and the improvement of mental health care (1991), and the UN Declaration of Commitment on HIV/AIDS (2001); indicating international awareness regarding this most perilous epidemic.

While all these instruments with relevance to health matters have either been adopted or approved by the UN General Assembly or the ECOSOC, strictly speaking they have no legally binding effect on states and governments. Still, the mere fact that these instruments have been followed by states, as if they were binding, has illustrated that they form an important component within the international movement to promote and protect the physical and mental health of all persons worldwide. Thus, a strategy fully applied voluntarily by states is as good as a treaty that has to undergo a cumbersome ratification and adoption process at the universal and national levels.

The treaty-based protection system

By contrast, the international treaty-based system works on the assumption that states will apply the international obligations for human rights protection in their own domestic law system as binding legal obligations. The international human rights system, as a consequence, has developed considerably over the last forty years. A large majority of states have by now ratified the key human rights treaties, such as the two Covenants, the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR)

of 1966, in force since 1976, or the Convention on the Rights of the Child (CRC) of 1989, or the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) of 1979. As a result, a solid blanket of human rights norms has been spread out, on which issues of human rights protection can be monitored at the international level.

In relation to the right to health, the ICESCR manifests the human right to health in its Article 12, stating that:

“1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.”

Other articles in the ICESCR address different aspects in the context of health, thus contributing to a comprehensive and integrated protection of the human right to health.

The ICCPR, as the parallel Covenant on civil and political rights, in its Article 6, stresses that States Parties are under an obligation to protect every human being's inherent right to life, and some States Parties have used this provision also in relation to the right to health, where no specific provision for that is to be found in constitutional or other legislative documents. In the area of international humanitarian law, the Geneva Conventions (1949) in their Common Article 3, as well as in both Additional Protocols of 1977 stress the eminent role for health care and protection in international and internal armed conflict situations.⁶

The network of international treaty law instruments with significance for the right to health is very elaborate.⁷ A listing of all relevant health-related norms would exceed the scope of this overview. To single out a recent addition, having direct effect on the realization of the right to health, let us note the WHO Framework Convention on Tobacco Control of 2003, setting up a secretariat and annual meetings in conferences of States Parties, has opted for the avenue of a legally binding instrument rather than mere

statements of policies and strategies to achieve its aims. The WHO thus is beginning to elaborate the possibilities of the legal approach alongside the well-tried policy approach.

The international treaties of recent years increasingly focus on vulnerable, disadvantaged or marginalized individuals and groups, and often highlight discrimination issues. The right to health is, however, also contained in regional international standards, such as the African Charter on Human and Peoples' Rights ("Banjul Charter"), Article 16; The African Charter on the Rights and Welfare of the Child, Article 14; the Revised European Social Charter, Articles 11 and 13; and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights ("Protocol of San Salvador"), Article 10. Indirect protection of health is also afforded by the American Convention on Human Rights, the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women, and the European Convention for the Protection of Human Rights and Fundamental Freedoms and its 14 Protocols.

The right to health is also recognized in numerous national constitutions,⁸ either directly, as in South Africa, or indirectly, as in India. Such indirect protection can be effected by judicial pronouncements, incorporating the right to health aspects in other human rights, explicitly guaranteed at the national level.⁹ In some countries, where the Constitution does not provide specifically for the right to health, elementary health care issues can be deduced from a more generic human rights provision, such as the human dignity provision read in conjunction with a "social state" or solidarity principle, as under the German Basic Law in Articles 1 and 20. These chapeau provisions serve as an umbrella of human rights protection, albeit restricted to guaranteeing the survival kit, the existential minimum, without which a life in dignity cannot be led.¹⁰

Right to health: Freedom and entitlements

If one looks at the complex nature of the right to health, several quite distinct dimensions have to be borne in mind: On the one hand, the right contains the freedom to make decisions about one's own health data; on the other hand, the right to health also embraces an entitlement to a system of health care protection. So the availability of health services, facilities and products of good quality represents a comprehensive dimension, while the

actual individual rights guarantee represents another, equally important dimension.

In 2000 the Committee on Economic, Social and Cultural Rights (CESCR) adopted General Comment No. 14 which outlines in great detail the various dimensions of the right to health.¹¹ The freedom dimension of the right to health includes questions of sexual and reproductive health, the right to be free from interference, such as non-consensual medical treatment. The entitlement dimension addresses such issues as the right to emergency medical services, and to the underlying determinants of health, such as adequate sanitation, safe and potable water, adequate food and shelter, safe and healthy working conditions, and a healthy environment. If these underlying determinants of health are not met, the right itself cannot properly be protected.

A lot of discussion centred on the question of entitlement to emergency medical treatment, particularly as regards undocumented immigrants. From a human rights perspective, such people are particularly vulnerable and in greatest need of immediate protection. Most developed countries, as receiving countries, resist such arguments, however, fearing that they cannot cope with the health problems of potentially huge numbers of undocumented immigrants. While General Comment No. 14 takes a broad approach which covers primary, secondary (specialist) and tertiary (high cost intensive medical treatments) health care, in the Committee's practice such people seem to be entitled to emergency treatment only, until such time that status questions are resolved. From the beginning non-governmental organizations have taken a broader view. But it must be remembered that General Comments set out to state the human rights law, as it is conventionally agreed, not what might be considered to be desirable. The Committee, like all treaty bodies, has to draw a fine line between interpreting – which it is entitled to do – and legislating, which is up to the contracting states. In the monitoring practice of the state reporting procedure, this distinction is not always applied strictly. Committee members may ask questions on the treatment availability for undocumented aliens, hoping that the State Party engages in a constructive dialogue on the issue. This way, the Government concerned may get recommendations from the Committee on how to change the legal bases of alien treatment situations at home, and the Committee can then follow up these recommendations in the next dialogue with the State Party.

Right to health: Availability, accessibility, acceptability and quality

General Comment No. 14 starts out by saying that the expression “right to highest attainable standard of health” in Article 12 of ICESCR is very broadly phrased, perhaps too broadly. But it certainly cannot be understood as a right to be healthy.¹² Thus the right contains both freedoms and entitlements. The notion of the “highest attainable standard of health” in Article 12(1) of ICESCR takes into account both the individual’s biological and socio-economic preconditions, and the state’s available resources. A number of important aspects cannot, however, be addressed solely within the relationship between the state and individuals. In particular, good health cannot be ensured by a state, nor can states provide protection against every conceivable cause of human ill health. Thus, genetic factors, individual susceptibility to ill health or the adoption of unhealthy or risky lifestyles, albeit important, cannot be attributed to the state. General Comment No. 14, therefore, restricts the right to health to a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the right to health.¹³ The right to health, as interpreted by the CESCR, contains four essential and inter-related elements: Availability, accessibility, acceptability and quality (the AAAQs).¹⁴

It is clear that health facilities, goods and services must be available in sufficient quantity within a given country. This includes, *inter alia*, hospitals, clinics, trained medical personnel, and availability of essential medicines according to the 20 or so essential drugs that the WHO Essential Drugs List contains. But it also comprises preventive public health strategies and promotional activities, such as awareness-raising campaigns against HIV/AIDS, or information as regards safe drinking water and adequate sanitation facilities. The issues connected with sanitation and water were only flagged in General Comment No. 14, but the right to water and sanitation was later elaborated in General Comment No. 15.¹⁵ The right to water and sanitation has now been given additional prominence by the institution of an Independent Expert on that issue, established by the Human Rights Council in 2008. The availability of health personnel is crucial in rural areas in many countries.

The dimension of accessibility without discrimination is next addressed in General Comment No. 14: It comprises non-discrimination, particularly for the marginalized and disadvantaged sections of the population, in law and in fact.¹⁶ It also addresses physical accessibility, i.e. within safe physi-

cal reach for all sections of the population, especially for the most vulnerable groups, such as ethnic minorities, indigenous peoples, women, children, adolescents, older persons, persons with disabilities, and particularly persons with HIV/AIDS. Thus, to take but one example, in many Saharan countries, girls have to walk a long way to collect water, and frequently are accosted by young men, so safe access to water is a clear priority for them. Most critical is the further aspect of economic accessibility (affordability); equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households. If a health centre charges user fees and those in need cannot pay the fee, the centre is not economically accessible. Needless to say, the exact amounts to be assessed are up to democratically elected parliaments and other processes at the national level.

The right to health also requires that health facilities must be respectful of medical ethics, they must also be culturally appropriate and gender-sensitive. There should be acceptability. Thus health workers need to be aware of cultural sensitivities in the provision of health care. For example, when women are examined by male doctors, a female nurse should be in attendance. Lastly, the quality of health care is a decisive factor. Facilities must be scientifically and medically appropriate, and of good quality. Thus, for example, provision of an expensive mammography machine to a health centre may not be scientifically and medically appropriate where human and technical resources are scarce, as in many less developed countries, and where the main issue for women is cervical cancer.¹⁷ Where health education is offered, it must be ensured that such education is of high quality.

The right to health, like all ESC-rights, is subject to progressive realization and resource availability. In the past, this has given rise to fundamental misunderstandings: This progressive nature was taken by some governments to mean that, unlike civil and political rights, economic, social and cultural rights merely represented programmatic goals or promotional obligations, non-self-executing norms, whereby it would be up to the State Parties concerned to decide, by way of discretion, if, and how, the right promised at the international level would be operationalized at the national level. As long as no implementation steps were taken at the domestic level, the right would only be subject to vague and general reporting and monitoring at the international level. It would amount only to very soft obligations. However, ever since its General Comment No. 3 in 1990, the Committee has consistently emphasized that this approach clearly contravenes the object

and purpose of the Covenant. Progressive realization and resource availability, mentioned in Article 2(1) of the Covenant, simply mean that states have to show how they have progressed in the realization of rights protection between two reporting phases, i.e. how the situation has improved over the last four years. This is not merely a programmatic obligation, but a clear and immediate obligation of the State Party.¹⁸ If no progress was made, or there was even regression, then the State Party is under a stringent legal obligation to explain why it could not fulfil the Covenant obligation. The question of resource availability, to which Article 2(1) also refers, is not a *carte blanche* for states to do as they please. While setting out a general standard, developed countries start from a higher level of rights realization than developing countries, which start from a much lower level of rights realization, on account of their economic situation. Nonetheless, even the developing country must take reasonable and deliberate targeted steps towards better realization of the right to health. Thus, for example, some obligations are not resource-dependent at all, but apply across the board, such as non-discrimination or equality issues. In addition, where developing countries are unable to meet even these minimal requirements, they are under an obligation to seek international cooperation and assistance. Developed countries as a corollary have an international obligation under Article 2(1) ICESCR to provide such cooperation and assistance, even though that obligation is not specified in any detail by way of concrete amounts. Many developed countries do indeed provide such assistance, but do so as a voluntary exercise, and consequently do not regard this assistance as part of their international legal obligations. The Committee, from the very beginning, has taken a different view, as recently outlined in its Statement on Resource Allocation,¹⁹ which the Human Rights Council requested the Committee to outline in connection with the adoption of the Optional Protocol to the ICESCR at the end of 2008.

Levels of protection for the right to health

Article 12 of ICESCR imposes three levels of obligation for States Parties: The first type of obligation, the obligation to respect, requires states to refrain from interfering directly or indirectly with the enjoyment of the right to health.²⁰ The state, as a matter of principle, has to avoid any action or activity which would hamper the equal enjoyment of access to preventive, curative or palliative health services, e.g. access to contraceptives, health-

related information or traditional preventive care, healing practices and medicines.

In General Comment No. 14, several examples are given to outline specific legal obligations resting on States Parties, such as preventing unequal access to health facilities, including for prisoners or detainees, asylum-seekers and undocumented immigrants, and the obligation to abstain from enforcing discriminatory health practices as a state policy, particularly vis-à-vis women, or the obligation to prevent the marketing of unsafe drugs and from applying coercive medical treatments, unless this is for the treatment of mental illness in exceptional and closely defined circumstances, or for the prevention and control of communicable diseases.

The State Party furthermore has obligations to protect which include, *inter alia*, the adoption of legislation, or the taking of other measures ensuring equal access to health care and health-related services provided by third or private parties. This means that the state, although not directly responsible for the administration of a particular health matter, still remains indirectly responsible, ensuring that the marketing of medical equipment, and of medicines provided by third parties, remain under the state's control. Thus, under this control function, the state has to ensure that medical practitioners, and other health professionals, meet appropriate standards of education, skills, and ethical codes of conduct. States also remain responsible for protecting their population from harmful traditional practices, interfering with access to pre and post-natal care and family planning, and to combat female genital mutilation where this still represents a widespread social practice.²¹

Under the obligation to fulfil, states are required, *inter alia*, to give sufficient recognition to the right to health in the national political and legal systems, and to adopt a national health policy containing detailed plans for realizing the right to health. States Parties must also provide adequate health care, including immunization programmes against the major infectious diseases. Public health infrastructures should also provide for sexual and reproductive health services, particularly in rural areas. Many other examples are given in General Comment No. 14, paragraph 36. States are also required to formulate, implement and review periodically a coherent national policy to minimize the risk of occupational accidents and diseases.²²

While these obligations seem to require a lot from each State Party, the Committee in General Comment No. 14 has made it abundantly clear that despite the multifarious legal obligations in relation to the freedom aspects

of the right to health and the entitlement components of that right, a relatively small but essential number of core obligations can be made out which all states, whether rich or poor, should be able to meet in all circumstances, because they are not resource-dependent, or only to a very limited degree, comparable to any civil or political rights situation. These core right to health obligations affect the “survival kit” or “existential minimum” which every person needs for survival and for leading a life in dignity. Furthermore, these core obligations reflect the actual practice of very many states at their domestic law level, and may be regarded as part of customary international law or even as general principles of law in the sense of Article 38(1) (c) of the Statute of the International Court of Justice (ICJ). Accordingly, states without exception are obliged:

“(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups, (b) to ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone, (c) to ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water, (d) to provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs, (e) to ensure equitable distribution of all health facilities, goods and services, and (f) to adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population ...”

These then are the minimum core obligations of the right to health which states must meet. Other obligations of comparable priority cover reproductive, maternal and child health care, and other duties outlined in the General Comment No. 14, paragraph 44.²³

Accountability structures

Increasingly, international attention is focussing on mechanisms of accountability in realizing the right to health. While the State Party reporting to treaty bodies provides some form of international control, more effective implementation of international obligations at the national level is required. A number of accountability mechanisms are available for that purpose.²⁴ Accountability involves states being answerable for their acts or

omissions regarding their right to health obligations. If no accountability mechanisms exist, the right to health will be largely meaningless or ineffective for right holders. Several different types of accountability mechanisms can be distinguished:

1. Judicial;
2. quasi-judicial;
3. administrative;
4. political; and
5. social.

Under judicial review of executive action or statutory or constitutional interpretation, at the national level, many examples can be given from various countries. To pick out but one, *Minister of Health v. Treatment Action Campaign*, the Constitutional Court of South Africa applied sections 27 and 28 of the South African Constitution when the question of access to essential drugs for HIV/AIDS patients was at issue, and drew on General Comments by the Committee to determine that health policy had to be reasonable in development and implementation. For a policy to be “reasonable”, it had to be comprehensive, coordinated between the various levels of government, and focussed on those in greatest need.²⁵

In many common law jurisdictions, quasi-judicial accountability mechanisms are a preferred option, such as dispute resolution by patients’ rights commissions or tribunals, health care commissions, and complaints tribunals or procedures, to be found in many other countries as well. In the United Kingdom, for example, the Health Care Commission submitted a review of maternity services in January 2008,²⁶ which revealed that only one in four National Health Service maternity services could be described as “best performing”. The Commission has indicated that it will conduct a follow-up review to check on progress on the recommendations made.

As far as administrative accountability mechanisms are concerned, there is an increasing use of the practice of requiring human rights impact assessments, borrowed from similar and well-tried practices in relation to environment protection measures.²⁷ That process seeks to reduce large scale potential negative impacts, and to enhance the potential positive impacts of a proposed action.

Another accountability mechanism centres on political processes, and obviously varies tremendously from one state to another. In this form of

action, parliamentary committee review of budget allocations and the use of public funds is at stake, and is usually exercised through democratically elected, or appointed, health councils and health care commissions.

Last, but certainly not least, social accountability is effected by civil society involvement, ranging from independent or collaborative forms of monitoring healthcare issues, and conducting public hearings and social audits, and frequently involving and attracting media attention.

When the right to health is reviewed for the effects it is having at the national level, the accountability mechanisms are a key component for the solution of health problems, but often there are no specific remedies. The international treaty-based system of protection is relatively weak, lacking concrete implementation at the domestic level. For this reason, international attention increasingly focuses on effective remedies. Providing quasi-judicial international monitoring, such as the production of views under communication procedures under the Optional Protocol of the ICCPR and under the Optional Protocol to the ICESCR, does not provide the real answer. For the right to health to be really meaningful, it needs to be given teeth: There must be adequate legal or other remedies provided at national level, open to any rights-holder claiming that his or her right to health has been violated.²⁸ The remedies available can be variegated, ranging from restitution or rehabilitation, via compensation, satisfaction and guarantees of non-repetition. To illustrate this, the case of *Grootboom and others v. Government of the Republic of South Africa and others*²⁹ may be looked at.³⁰ A group of adults and children had moved onto private land from an informal settlement. They were subsequently forcibly evicted from the private land, and camped on a sports ground in the area. They could not erect sufficient shelter, as most of their belongings had been destroyed during the eviction measure. During the High Court proceedings, various levels of government (municipal, regional and national) made offers to ameliorate the immediate crisis situation for the group, which they accepted. When four months later it appeared that none of the government levels had fulfilled their promises, the Constitutional Court made an order which included the provision of a specified number of temporary toilets and taps pending the construction of permanent toilets and water taps on the sports ground. As a matter of the rule of law, many jurisdictions will not allow courts to replace policy decisions of parliament or of the executive by its own policy choice, unless – as in the *Grootboom* case – there is a discretion reduction to zero, where only

one possible lawful answer remains. In that case only can a court adjudicate accordingly. And this obviously applied in the *Grootboom* case.

In state practice, courts on the whole will tread very cautiously when it comes to decisions involving allocation of large sums of money. Thus, in the case of *Soobramoney v. Minister of Health, Kwa-Zulu-Natal*³¹ in view of a shortage of funds, a policy had been adopted in which automatic access to dialysis was limited to patients suffering from acute renal failure. For those suffering from chronic renal failure, access to dialysis was provided only if they were eligible for a kidney transplant. A medical ethics commission had assessed that more people could be kept alive through application of this policy than if untreatable patients were allowed to use the few available dialysis machines. The applicant did not belong to the class of beneficiaries on account of his chronic renal failure, having also had unsuccessful kidney transplants, and as he also suffered from multiple forms of cancer. His claim that his right of access to health care services under Article 27 of the South African Constitution had been violated was rejected by the Constitutional Court. Justice Sachs observed that “[w]hen rights by their very nature are shared and inter-dependent, striking appropriate balances between the equally valid entitlements or expectations of a multitude of claimants” is a matter of “defining the circumstances in which the rights may most fairly and effectively be enjoyed”.³² Hence the Court concluded that the circumstances in which dialysis treatment could most fairly and effectively be enjoyed were not those of the applicant. So no violation of the right to health was found.

Health indicators and benchmarks

Another difficulty that health rights activists have addressed in recent years is the fact that very often the country analysis does not lend itself to in-depth analysis, because neither the Committee as treaty body, nor the State Party, are fully aware what data should be utilized in measuring the performance of the state during the reporting period. For that reason, indicators have been elaborated which should facilitate that task. Numerous research projects have been carried out in recent years in this respect, but while everyone agrees that only a relatively small number of health indicators should be employed, manageable for the reporting state, as soon as one delves further into the matter by asking WHO specialists and other

health officials for indicators, soon a huge number of such indicators are proposed. The ideal of having just a handful of key indicators for each human right has proved to be illusory. Utilization of benchmarks, which are self-set targets set by States Parties, can be of assistance here. But as the Indicators, Benchmarks, Scoping and Assessment Project of Mannheim University has shown (the IBSA process),³³ once agreed benchmarks have been applied, and then measured (“assessed”) five years later, there may well be clearer notions of relevant indicators to be used for monitoring purposes. But so far, although several of the Committee’s recent General Comments have reminded states of the benchmarking of indicators, no state has actually negotiated with the Committee as yet on the details of such focussed monitoring. Two developed countries have recently indicated that they are prepared to begin such new forms of focussed reporting.³⁴ In the reporting guidelines of the Committee, quite a few indicators are already to be found, and it now only needs a renewed conceptual effort in a spirit of cooperation between the State Party concerned and the Committee. While the CESCR probably has advanced most in this sphere so far, other treaty bodies, and the Office of the High Commissioner for Human Rights itself, are presently analysing this approach, across all major human rights treaties. Realizing the right to health will undoubtedly benefit from this approach and may become more effective at the normative international level, and particularly when it comes to implementing that right at the national level.

The way ahead

The right to health has by now been recognized as a fundamental human right, and case law from several countries underpins the international treaty obligations. In the years and decades to come, questions surrounding healthcare, health conditions and protection of everyone’s right to health will continue to play a prominent role in international and national efforts to improve lives, especially of those who suffer under harsh living conditions and whose other human rights are utterly neglected. In particular, the right to health will increasingly be intertwined with the fight against extreme poverty and hunger, with further regimes regulating intellectual property (including patents), as well as connecting to decisions about scientific and genetic research, and with overarching issues of environment protection. For instance, it will be interesting to observe whether the right to health and the Agreement on Trade-Related Aspects of Intellectual Prop-

erty Rights, Including Trade in Counterfeit Goods (TRIPS) can be harmonized, in order to make drugs, especially those which are essential for the battle against epidemics like HIV/AIDS, available to everyone in need. The exceptions to the General Agreement on Tariffs and Trade (GATT) might be read more with a human rights focus than purely from the perspective of a market economy.³⁵ Along with international intellectual property law, international trade law will have to, at least, integrate issues related to health care and protection into its relevant rules.

Another key aspect that will continue to be central to this debate, and which signals dangers for the universal realization of the right to health, is the concept of privatization, whether directly in the field of healthcare, or on the periphery (access to water, education, use of infrastructure). It will be incumbent on states and on the international community to strike the right balance between (private) economic interests and basic human needs. The Committee on Economic, Social and Cultural Rights, as the Covenant monitoring body, has regularly addressed these issues and emphasized that, while the policy choices involved are left to the discretion of states, nevertheless, the human rights effects of such actual policy choices will be closely monitored, in line with Article 12 of ICESCR. Most states now accept that the right to health is a fundamental human right, and are now beginning to take a rights-based approach in their national law implementation measures. But much still remains to be done to get the greatest possible attention to this human right at the domestic level, so that in particular, the marginalized and disadvantaged groups of society will be able to realize their elementary health needs, necessary for survival and for leading a dignified life.

- 1 The earliest known water supply and drainage systems were set up in ancient Egypt, India and Greece, and by the Inca society in America, see Eibe Riedel, 'The International Protection of the Right to Health', in Rüdiger Wolfrum et al. (eds.) *Encyclopedia of Public International Law* (Heidelberg: Max Planck, 2008); see also Brigit C. A. Toebes, *The Right to Health as a Human Right in International Law* (Antwerp: Intersentia, 1999), at 7 et seq.; Jonathan Mann, Laurence Gostin, Sofia Gruskin, Troyen Brennan, Zita Lazzarini, Harvey Fineberg, 'Health and Human Rights' in *Health and Human Rights* (New York/London: Routledge, 1999), at 9 et seq.
- 2 UN Commission on Human Rights, Resolution 2002/31, 22 April 2002; See also the Human Rights Council, Resolution 6/29, 14 December 2007.
- 3 See, e.g., Commission on Human Rights, 'The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS)', Resolution 1999/49, 27 April 1999.
- 4 Commission on Human Rights, 'International Guidelines on HIV/AIDS and Human Rights', UN Doc. E/CN.4/1997/150 (1997).
- 5 Commission on Human Rights, 'Access to medications in the context of pandemics such as HIV AIDS, tuberculosis and malaria', Resolution 2003/29, 22 April 2003.
- 6 For example, Article 11 of Additional Protocol I, which protects the "physical and mental health and integrity of persons", and Article 4 of Additional Protocol II prohibits "violence to the life, health and physical well-being of persons".
- 7 Eibe Riedel, 'New Bearings to the State Reporting Procedure: Practical Ways to Operationalize Economic, Social and Cultural Rights – the Example of the Right to Health', in S. von Schorlemer (ed.) *Praxishandbuch UNO* (Berlin: Springer, 2003), at 345–358.
- 8 Cf. E. Kinney and B. Clark, 'Provisions for Health and Health Care in the Constitutions of the Countries of the World', 37 *Cornell International Law Journal* 2004, at 285.
- 9 For a good case study, see H. Potts, 'Accountability and the Right to the Highest Attainable Standard of Health', Open Society Institute, Public Health Programme, University of Essex, Human Rights Centre, 2008, Appendix I, case studies 3 and 4 – India, at 33–35.
- 10 Eibe Riedel, 'International Law Shaping Constitutional Law', in Eibe Riedel (ed.), *Constitutionalism: Old Concepts, New Worlds* (Berlin: Berliner Wissenschafts-Verlag, 2005, p. 105–121, at 115.
- 11 Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14 on the right to the highest attainable standard of health*, 11 August 2000, UN Doc. E/C.12/2000/4.
- 12 *Ibid.*, at para. 8.
- 13 *Ibid.*, at para. 9, last sentence.
- 14 *Ibid.*, at para. 12 a–d.
- 15 Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 15 on the right to water*, 20 January 2003, UN Doc. E/C.12/2002/11.
- 16 The CESCR is presently preparing General Comment No. 20 on Article 2(2) of ICESCR, addressing non-discrimination.
- 17 Cf. Potts, *supra* note 9, at 10.
- 18 General Comment No. 14, *supra* note 11, at para. 30.
- 19 Statement on Evaluation of the Obligation to Take Steps to the "Maximum of Available Resources" under an Optional Protocol to the Covenant, 10 May 2007, UN Doc. E/C12/2007/1; for details see Eibe Riedel, 'Zur Durchsetzung wirtschaftlicher, sozialer und kultureller Rechte im Völkerrecht', in Th. Giegerich, A. Zimmermann, U. Heinz (eds.) *Wirtschaftliche, soziale und kulturelle Rechte im globalen Zeitalter* (Berlin: Dunker and Humblot, 2008), 71–93, at 83–85.
- 20 General Comment No. 14, *supra* note 11, at para. 34.
- 21 *Ibid.*, at para. 35.
- 22 *Ibid.*, at para. 36.
- 23 Paragraph 44 of General Comment No. 14 states: "The Committee also confirms that the following are obligations of comparable priority: (a) To en-

- sure reproductive, maternal (pre-natal as well as post-natal) and child health care; (b) To provide immunization against the major infectious diseases occurring in the community; (c) To take measures to prevent, treat and control epidemic and endemic diseases; (d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them; (e) To provide appropriate training for health personnel, including education on health and human rights.”
- 24** See Potts, *supra* note 9, at 13 et seq.
- 25** *Minister of Health v. Treatment Action Campaign (TAC)* (2002) 5 SA 721 (CC).
- 26** See United Kingdom Healthcare Commission, ‘Key finding of the 2007 Maternity Service Review’, 25 January 2008, available at http://www.healthcarecommission.org.uk/_db/_documents/Maternity_FINAL_BRIEFING_NOTE.doc.
- 27** See Paul Hunt and Gillian MacNaughton, ‘Impact Assessments, Poverty and Human Rights: A Case Study Using the Right to the Highest Attainable Standard of Health’, available at http://www2.essex.ac.uk/human_rights_centre/rth/projects.shtm; Potts, *supra* note 9, at 20.
- 28** On the violations approach, see generally Audrey Chapman, ‘The Right to Health’, in Audrey Chapman and Sage Russell (eds.), *Core Obligations: Building a Framework for Economic, Social and Cultural Rights* (Antwerp: Intersentia, 2002) at 185–216.
- 29** *The Government of South Africa v. Grootboom*, Constitutional Court of South Africa, 2000 ICHRL 72, 21 September 2000.
- 30** Cf. Eibe Riedel, ‘Measuring Human Rights Compliance: The IBSA Procedure as a Tool of Monitoring’, in Andreas Auer, Alexandrew Flückiger, Michel Hottelier (eds.) *Études en l’honneur du Professeur Giorgio Malinverni : Les Droits de l’homme et la constitution* (Geneva, Schulthess, 2007), 251–272, at 256 et seq.; Riedel, *supra* note 7, at 117.
- 31** CCT 32/97, 27 November 1997; discussed in Susan Marks and Andrew Clapham, *International Human Rights Lexicon* (Oxford: Oxford University Press, 2005) 197–208, at 207.
- 32** *Soobramoney v. Minister of Health KwaZulu Natal* 1997 (12) BCLR 1696, at para. 54.
- 33** Riedel, *supra* note 7, at 256 et seq.; Eibe Riedel, ‘Monitoring the 1966 International Covenant on Economic, Social and Cultural Rights’, in International Labour Organization (ILO), *Protecting Labour Rights as Human Rights: Present and Future of International Supervision*, (Geneva: ILO, 2007) at 3–13, particularly at 8–9.
- 34** In 2008 France and Australia informally indicated that they are, in principle, prepared to engage in such a new type of reporting.
- 35** For an insightful and critical analysis in relation to the right to food as a corollary to the right to health, see H. M. Haugen, *The Right to Food and the TRIPS Agreement* (Leiden/Boston: Brill, 2007), particularly at 213–251.

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