

Enforcing the Right to Health: Innovative Lessons from Domestic Courts

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The United Nations Committee on Economic, Social and Cultural Rights, in its General Comment No. 9, has emphasized that it is up to states how they give effect to the rights contained in the International Covenant on Economic, Social and Cultural Rights (ICESCR), including the right to health, but whatever arrangements they choose they must be effective: “The Covenant norms must be recognized in appropriate ways within the domestic legal order, appropriate means of redress, or remedies, must be available to any aggrieved individual or group, and appropriate means of ensuring governmental accountability must be put in place.”¹

This chapter highlights some significant right to health cases in a non-exhaustive survey of decisions from domestic courts from both civil and common law jurisdictions. In so doing it seeks to show that (a) even where the right to health is explicitly guaranteed under the constitution, courts will still have to wrestle with challenging issues, such as resource allocation and (b) by adopting innovative approaches, the lack of express constitutional entrenchment of the right to health in domestic law is not necessarily a bar to both consideration, and enforcement, by the courts. In the latter case, courts have attempted to give practical meaning to notions of indivisibility and interdependence of rights recognizing that the right to health has clear links to many other rights, not just economic and social but also civil and political rights – e.g. the right to life and, the right not to be subjected to torture or cruel, inhuman or degrading treatment, and the right to information² – an unhealthy citizen is not able to play a full and active part in society either economically or politically.

Constitutional entrenchment: Addressing systemic violations whilst considering resource implications

Since Chile provided the first constitutional recognition of the right to health in 1925, nearly 70% of countries have some form of explicit guarantee regarding health, although this may take a variety of forms.³ In South Africa the guarantee is part of a provision requiring access to health care services, food and water and social security.⁴ Since the new Constitution came into force in 1994, health rights, together with housing rights, have provided the most significant constitutional economic, social and cultural rights cases considered by the courts to date. Two cases seek to highlight how the Constitutional Court sought to address issues of widespread violations affecting thousands of people and limited resources.

Arguably the most widely known case to be decided by the Constitutional Court to date, due not just to the issues involved, but also because of the successful campaign surrounding it (a frequently critical factor in ensuring enforcement), is *Minister of Health v. Treatment Action Campaign (TAC)* (2002) 5 SA 721 (CC), or the *TAC case*, where it was held that the state's failure to provide comprehensive anti-retroviral drugs to prevent mother-child HIV transmission breached their right to health. An important factor for the court was the fact that the drug was costless to the government and therefore arguments centred on lack of resources did not carry any weight. However, by requiring that the programme should include reasonable measures for counselling and testing, the court did make orders, with some (albeit limited) financial implications. Beyond this, and unlike the approach often taken by the Indian Supreme Court and the Inter-American Court of Human Rights, the court refrained from discussing detailed modes of implementation. Arguably, this created subsequent problems since it took several months of campaigning and lobbying by TAC and others to force the authorities to act and start supplying the drugs.

In *Soobramoney v. Minister of Health KwaZulu Natal* 1997 (12) BCLR 1696, the Constitutional Court set out its approach to examining right to health claims within the context of limited resources. The court, in considering a terminally ill patient's claim to access medical services to obtain costly dialysis treatment, which had been refused by the local health authority on the grounds of lack of resources, held that the health authority had acted reasonably and applied its guidelines rationally and fairly. In so doing the court (as it has done in subsequent cases) asked the crucial question: Has

the state done all it could reasonably do in the circumstances?⁵ By adopting this approach, similar to judicial review, although extending beyond the decision-making process to consider all the actions taken, the court has recognized that it is not in a position to assume the role of the state in making decisions about resource allocation, but is, instead, there to act as an impartial arbiter. Indeed in *Soobramoney* the court was very explicit about the large margin of discretion it would give to the state to set budgetary priorities stating that the court “will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities.”⁶ Justice Sachs went further, stating that: “In open and democratic societies based upon dignity, freedom and equality, the rationing of access to life-prolonging resources is regarded as integral to, rather than incompatible with, a human rights approach to health care.”⁷

A region where the courts have been extremely proactive in addressing systemic violations, even where there are significant resource implications for their decisions, has been Latin America. In a number of decisions from different jurisdictions – e.g. Peru,⁸ Venezuela,⁹ Argentina,¹⁰ Brazil¹¹ and Ecuador¹² – courts, frequently responding to *amparo*¹³ actions, have handed down landmark decisions guaranteeing access to medicines and/or treatment, affecting thousands of victims, and requiring states to take concrete and immediate action, rather than a progressive realization approach. One of the leading decisions is *Mariela Viceconte v. Ministry of Health and Social Welfare* Case No 31.777/96 (1998) from Argentina in 1998.¹⁴ The claim was brought by a number of community groups to ensure that the state would manufacture a vaccine against Argentine hemorrhagic fever, then threatening the lives of 3.5 million people, most of whom did not have adequate access to preventive medical services in certain affected areas. Whilst the state had been able to obtain 200 000 doses of a vaccine from the United States, and had been able to vaccinate 140 000 people between 1991 to 1995, it was unable to carry out a massive immunization campaign due to the lack of an adequate quantity of vaccine. A judicial writ of *amparo* was filed requiring the health ministry to manufacture and distribute further supplies of the vaccine to persons living in the affected areas. Following initial rejection, the Court of Appeals ruled favourably, establishing the state’s obligation to manufacture the vaccine¹⁵. Significantly (and unlike in South Africa) the court also set a legally binding deadline for the obligation to be met. However, as in the South African *TAC* case, it required further action by the groups, including litigation, to secure enforcement.

Ultimately cases such as *Mariela Viceconte* can have a political, as well as legal impact, far beyond that perhaps envisaged when the original petition was submitted. Within five years, Argentina had developed a social plan to deliver basic medicines. The roots of this plan can be directly traced to the *Viceconte* case.

Lack of constitutional entrenchment: The need to adopt innovate approaches

The lack of express constitutional protection for health rights presents courts with significant but not insurmountable challenges for enforcement. Techniques include:

1. Adopting expansive definitions of civil rights, some of which tend to be widely, if not universally, guaranteed under national law, e.g. rights to life or not be subjected to cruel, inhuman or degrading treatment. This approach has been sanctioned to differing degrees by both the UN Human Rights Committee¹⁶ and the European Court of Human Rights;¹⁷
2. Considering the due process issues by exercising some form of judicial review;¹⁸
3. The use of cross-cutting provisions such as equality and non-discrimination, which, again, may not allow for consideration of the substantial economic or social right, but at least afford some measure of indirect protection.

The Indian story: Activism and innovation

Although South Africa has tended to attract much of the attention, at least among common law jurisdictions, for its protection of economic and social rights, Indian courts have been at the forefront of economic, social and cultural rights litigation for over three decades. The Indian Constitution, promulgated in 1947, is a creature of its age and on its face is far less progressive than its South African counterpart operating from the mid 1990s. Economic and social rights, including the right to health contained in Article 47 of the India Constitution¹⁹ are consigned to the Directive Principles of State Policy (DPSP) section which, according to Article 37 of the Constitution, “shall not be enforceable by any court, but the principles therein laid

down are nevertheless fundamental in the governance of the country and it shall be the duty of the state to apply these principles in making laws.”

Therefore on its face, the Supreme Court of India is barred from considering and enforcing individual health rights claims; but rather it is concerned with offering non-binding guidelines on how health policies should be implemented, whilst leaving the final decision to the state. However, the early 1970s witnessed a watershed in Indian human rights litigation with the *Fundamental Rights Case*.²⁰ This case ushered in an unprecedented period of progressive jurisprudence, following the recognition by the court that DPSP should enjoy the same status as “traditional” fundamental rights. At the same time, rules on standing were relaxed in order to promote public interest litigation and access to justice. Suddenly writ petitions could be submitted on a postcard.²¹

The main means by which the Supreme Court has achieved equivalence between civil rights and their economic and social counterparts has been through the application of an expansive definition of the right to life. Unsurprisingly the right to health was one of the guarantees to first benefit from this approach.²² In the public interest litigation case of *Paschim Banag Khet Samity v. State of West Bengal* (1996) 4 SCC 37 the Supreme Court used the right to life to secure the right to emergency medical care, concluding that such an essential obligation could not be avoided by pleading financial constraints.²³ The court, in holding that there had been a violation of the right to life under Article 21, and awarding compensation, stated that the right to emergency medical care formed a core component of the right to health which in turn was recognized as forming an integral part of the right to life. It did this by reconceptualizing the right to life as imposing a positive obligation on the state to safeguard the life of every person, stating that “*preservation of human life was of utmost importance*” and that: “The Constitution envisages the establishment of a welfare state ... Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the government in this respect [and it] discharges this obligation by running hospitals and health centres.”²⁴

In line with its general approach of frequently offering comprehensive remedies that go beyond merely providing redress for the victim, but also laying down the necessary policy and administrative steps to be taken by the state in the wider public interest, the court not only ordered compensation, but also directed the type of facilities that the state government

had to provide.²⁵ The court also ruled that its orders should apply to other states, together with the national government, and that these other states should be sent a copy of the judgment.

However, the court has also recognized that state resources are not unlimited:

“No State or country can have unlimited resources to spend on any of its projects. That is why it only approves its projects to the extent it is feasible. The same holds good for providing medical facilities to its citizens including its employees. Provision for facilities cannot be unlimited. It has to be to the extent finances permit. If no scale or rate is fixed then in case private clinics or hospitals increase their rate to exorbitant scales, the State would be bound to reimburse the same.”²⁶

How the court reconciles this general pragmatic approach with its recourse, on occasion, to orders with clearly significant cost implications, is not clear, and has certainly led to the Indian approach not being adopted in other common law jurisdictions beyond the South Asian region.

Another important line of public interest litigation cases impacting on rights to health have been those concerning protection of the environment, not only reinforcing the links between environmental rights and rights to health and to life, but also exemplifying the judicial activism for which the Indian courts have become well known. However, in so doing the courts have had to contend with the frequent charge that their orders are inconsistent with existing statutes, and that they have illegitimately extended their jurisdiction into an area of competence normally reserved for the executive. The Supreme Court has responded to such charges by stating that such directions are necessary to safeguard people’s right to health and therefore should trump statutory provisions. On this basis the court has justified taking major policy decisions rather than a stricter adherence to the separation of powers’ doctrine.²⁷

This activist approach has had an impact beyond India’s own borders to other countries in the South Asian region with similar constitutional arrangements to India. The result is that courts in Bangladesh and Pakistan have adopted equally progressive interpretations on the fundamental nature of economic, social and cultural rights.²⁸ At the same time other countries, such as New Zealand, with a restrictive Bill of Rights, have also utilized the right to life principle to indirectly protect health rights.²⁹

Pushing the envelope so far: Further creative approaches from other jurisdictions

Canada has no express provision protecting the right to health in its Charter of Rights and Fundamental Freedoms. Yet this has not prevented the Supreme Court from indirectly offering protection to the right by using other provisions. In particular, the equality provision under Article 15 has been used to protect economic, social and cultural rights on the basis that similar treatment may not always guarantee substantive equality, so that one achieves, according to one of its leading proponents, former Supreme Court Justice L'Heureux-Dubé, a contextual and empathetic approach to ensuring each person's human dignity.³⁰ In this context the court has ruled that, whilst section 15 does not impose upon the government the obligation to take positive action to remedy the symptoms of systematic inequality, it does require that the government should not be a further source of inequality.³¹ In particular, the government should ensure that, in providing general benefits to the population, they should guarantee that disadvantaged members of society have the resources to take full advantage of these benefits and, in this context, effective communication was an indispensable component of the delivery of medical services. To hold otherwise was, for the Supreme Court, a "thin and impoverished view ... of equality."³²

The UK courts, in the absence of any express right to health or any other economic and social rights guarantees incorporated into national law (with some limited exceptions),³³ can only apply the limited set of fundamental civil and political guarantees contained in the European Convention on Human Rights (ECHR) and incorporated through the Human Rights Act 1998.³⁴ In particular, in relation to the right to health this has involved the protection against cruel and inhuman treatment and respect for private and family life (but not right to life³⁵). However, it is important to recognize that in the United Kingdom (UK), as in other jurisdictions where health rights are not entrenched, this is still very much an emerging area of law, and that recent cases provide a mixed record at best.

Cases have included the question of the extent of the state's positive obligations to provide healthcare regarding a claim for reimbursement of costs following treatment abroad. Here the High Court recognized that the jurisprudence of the European Centre of Human Rights demonstrates that Articles 3 and 8 of the European Convention on Human Rights not only impose negative obligations not to act in a particular way, but also, in certain circumstances, impose positive obligations to take measures designed

to ensure that those rights are effectively protected.³⁶ The courts have addressed the failure of a local authority to sufficiently consider a patient's right to private life under Article 8 of the ECHR when deciding to transfer her to a nursing home.³⁷ And a number of cases have dealt with the health of asylum-seekers.

Asylum-seekers, clearly a particularly vulnerable segment of any population, have been the subject of both positive and negative decisions. In a landmark judgment, the House of Lords in *Secretary of State for the Home Department v. Limbuela & Ors* [2005] UKHL 66³⁸ held that asylum-seekers should not be thrown into destitution by denying them access to welfare benefits. In this respect the state has a duty under Article 3 of the ECHR to prevent homeless asylum-seekers from suffering destitution even where they had failed to make an asylum claim as soon as was reasonably practicable.³⁹

Whilst *Limbuela* could be successfully argued using the right to protection against cruel, degrading or inhuman treatment, other decisions illustrate the difficulties presented by the high threshold required to engage this safeguard. In *N v. Secretary of State for the Home Department*⁴⁰ the House of Lords found that that the UK had not breached Article 3 of the ECHR by deporting a failed asylum-seeker with terminal HIV/AIDS back to her country of origin, despite the fact that Uganda's medical facilities were clearly significantly less advanced than the UK.⁴¹ For their Lordships, a claim would only succeed where "the applicant's medical condition has reached such a critical state, that there are compelling humanitarian grounds for not removing him or her to a place which lacks the medical and social services which he or she would need to prevent acute suffering."⁴²

Therefore Article 3 did not require contracting states to undertake the obligation of providing aliens with indefinite medical treatment lacking in their home countries. To hold otherwise, they maintained, would be to open the floodgates to a myriad of claims placing an unreasonable burden on the state. Whilst expressing sympathy for the appellant's plight, and reminding the Home Secretary that he was not bound to deport her, but could exercise his discretion, their Lordships concluded that she should not be allowed to remain in the host state to enjoy decades of healthy life at the expense of [the] state."⁴³ Yet their Lordships admitted themselves, that, without the necessary medication she had been receiving in the UK, the appellant's life expectancy could be two years at best, and in Uganda treatment was available only at considerable cost.

In May 2008 the European Court of Human Rights upheld the Lords' decision finding that:

“The fact that the applicant’s circumstances, including his life expectancy, would be significantly reduced if he were to be removed from the Contracting State is not sufficient in itself to give rise to breach of Article 3. The decision to remove an alien who is suffering from a serious mental or physical illness to a country where the facilities for the treatment of that illness are inferior to those available in the Contracting State may raise an issue under Article 3, but only in a very exceptional case, where the humanitarian grounds against the removal are compelling.”⁴⁴

Indeed, to date, the court has only concluded on one occasion that such exceptional circumstances have merited a stay of deportation – where the applicant was critically ill and appeared to be close to death, could not be guaranteed any nursing or medical care in his country of origin and had no family there willing or able to care for him or provide him with even a basic level of food, shelter or social support.⁴⁵ It is clear that both the House of Lords, as they themselves recognized, and the European Court of Human Rights faced difficult moral choices in the case. Yet, whilst acknowledging that a line must be drawn somewhere to prevent the state (even one as wealthy as the UK) from becoming overburdened, the scope of the protection offered to desperately ill people in the wake of the decision appears too narrow.⁴⁶

Conclusions

This limited survey of right to health jurisprudence has demonstrated that express codification is not a bar to enforcement of issues impacting on the right to health by courts. However, such judicial enforcement will often require a creative approach and a generous interpretation of existing guarantees, by both lawyers and judges, in order to give true meaning to the principles of the indivisibility and interdependence of rights.

- 1 Committee on Economic, Social and Cultural Rights, *General Comment No. 9 on the domestic application of the Covenant*, 3 December 1998, UN Doc. E/C.12/1998/24, at paras. 1 and 2.
- 2 See, for example, the decision of the European Court of Human Rights in *Guerra v. Italy* (1998) 26 EHRR 357 with respect to the lack of available information on a facility which threatened the health of the applicants.
- 3 See Eleanor Kinney and Brian Clark, 'Provisions for Health and Health Care in the Constitutions of the Countries of the World' 37 *Cornell International Law Journal* (2004) 285 in which they calculate that 67.5% of constitutions have provisions regarding health and health care. Examples include a right to free medical services (Guyana); a right to a healthy environment (Hungary); a right to enjoy the highest possible level of physical and mental health (Hungary again) and a direct relationship to the right to life (Haiti).
- 4 Article 27(1) of the Constitution of the Republic of South Africa provides: '(1) Everyone has the right to have access to (a) health care services, including reproductive health care; (b) sufficient food and water; and (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance. (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights. (3) No one may be refused emergency medical treatment.'
- 5 See the landmark decision of *Government of RSA v. Grootboom* 2000 (11) BCLR 1169 (CC).
- 6 *Soobramoney*, para. 29.
- 7 *Ibid.*, para. 52.
- 8 *Azanca Alhelí Meza García*, Expediente No. 2945-2003-AA/TC: Amparo action seeking drugs needed to treat HIV/AIDS upheld by the Constitutional Court which ordered full treatment to be provided regardless of resource implications and subject to immediate and concrete state action. Consequently, the case is seen as a key precedent for the enforceability of social rights in the country.
- 9 *Cruz del Valle Bermúdez y otros v. MSAS s/amparo*, Expediente No. 15.789, Sentencia N° 196: Amparo action to obtain supply of the drugs needed to treat persons living with HIV/AIDS upheld by the Supreme Court which urged the Health and Assistance Ministry to deliver the drugs on a regular and reliable basis. The order also required appropriate budgetary allocation and to develop preventive policies including information, awareness, education and full assistance programmes. See also *López, Glenda y otros c. Instituto Venezolano de los Seguros Sociales (IVSS) s/ acción de amparo*, Expediente No. 00-1343, Sentencia No. 487, where it was also affirmed that a group of HIV infected people could petition the court on behalf of those similarly affected. In another landmark case, *Programa Venezolano de Educación-Acción en Derechos Humanos (PROVEA) y otros c. Gobernación del Distrito Federal s/ Acción de Protección*. Expediente No. 3174, the Caracas City Juvenile Court ordered that the state must provide timely and adequate surgical treatment in order to protect young people's rights to life and to health. Accordingly, the state was under a duty to guarantee sufficient budgetary allocations in order to fully equip a surgery room, together with the creation of a dialogue table aimed at identifying and addressing problems with hospital facilities.
- 10 *Menores Comunidad Paynemil s/acción de amparo* (2/03/1999): The Appeals Court upheld amparo action seeking protection for the health of indigenous children and youth due to consumption of water contaminated with lead and mercury. The state was found to have arbitrarily failed to diligently protect the right to health and was ordered to provide drinking water to the victims, to determine the existence of damages and, if required, to ensure adequate medical treatment. The case is considered to be one of the most important Argentinian precedents regarding enforceability. See also *Quevedo Miguel Angel y otros c. Aguas Cordobesas S.A. Amparo* (8/04/2002) where the Civil and Commercial Court of First

Instance of the City of Cordoba held that a water services company had the right to reduce, but not completely cut, the water supply to a group of low-income and indigent families due to non-payment. The right to have access to the provision of drinking water concerned the individual right to health and physical integrity.

- 11 *Estado do Rio de Janeiro* AgR No. 486.816-11: Duty of the state to supply medication to patients without the resources to afford the necessary medications. See also *Bill of Review* 0208625-3 (August 2002) in which the Special Jurisdiction Court of Parana held that an individual's disconnected water supply should be immediately reconnected to safeguard his constitutional rights particularly in light of the vulnerability of one of the residents due to sickness.
- 12 *Mendoza & Ors v. Ministry of Public Health* Resolution No. 0749-2003-RA (28 Jan 2004): The Constitutional Court held that the Ministry of Health had failed in its obligation under Article 42 of the Constitution to protect the right to health by suspending a HIV treatment programme. The court also held that although the right to health is an autonomous right, it also forms part of the right to life. In so doing it envisaged that a right to health entitled citizens not only to take legal action for the adoption of policies and plans related to general health protection, but also to demand that appropriate laws be enacted and that the Government provide the necessary resources.
- 13 A constitutional remedy providing individual relief.
- 14 For a further discussion of the case see Victor Abramovich, 'Argentina: The Right to Medicines' in *Litigating Economic, Social and Cultural Rights: Achievements, Challenges and Strategies* (Geneva: COHRE, 2003). Abramovich states that the case is seen as important for a number of reasons. It reaffirmed the judicial process as a method for enabling ordinary citizens to challenge state agencies regarding the merit of health policies; it saw the direct application by a domestic court of international standards on the right to health, thereby expanding the scope for further realization of economic, social and cultural rights; it imposed personal responsibility on two ministers for the manufacture of the vaccine with a specific deadline, thereby demonstrating that the obligations arising from economic, social and cultural rights are legal in nature, and entail legal liabilities; and it affirmed the role of the state as guarantor of the right to health in the event that the private sector is unable or (more likely) unwilling to provide the necessary services.
- 15 In reaching its judgment the court drew on regional and international human rights standards, including the American Declaration on the Rights and Duties of Man, and the Universal Declaration of Human Rights, but particularly the right to health under Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), all of the instruments having been incorporated into domestic law in Argentina and considered to form part of the Constitution. This was in direct response to the petitioners' assertion that where a state is facing a major health problem threatening a significant numbers of lives, the legal obligation under Article 12 of the ICESCR is particularly strong.
- 16 See the Human Rights Committee's General Comment No. 6, para. 5 on the right to life: "The right to life has been too often narrowly interpreted. The expression 'inherent right to life' cannot properly be understood in a restrictive manner, and the protection of this right requires that states adopt positive measures. In this connection, the Committee considers that it would be desirable for states parties to take all possible measures to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics." Human Rights Committee, *General Comment No. 6 on the right to life*, 30 April 1982, UN Doc. HRI/GEN/1/Rev.6, at 127 (2003).
- 17 In the case of *Osman v. UK* 29 EHRR 245 (2000) the Court recognized the positive obligations on the state to protect the right to life (in this case

- for the police in relation to threats to the victim made by another individual).
- 18 This has tended to be the approach adopted by the British courts in the absence of any express constitutional protection, but suffers from the fact that only the reasonableness of the decision-making process itself is considered, rather than the substance of the right, although it may still allow for some indirect protection of economic, social and cultural rights (see further below).
 - 19 Article 47 provides: 'The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purpose of intoxicating drinks and of drugs which are injurious to health.'
 - 20 *Keshavananda Bharati v. State of Kerala* (1973) 4 SCC 225.
 - 21 For a good overview of the Indian courts' approach to economic, social and cultural rights see S. Muralidhar, 'Justiciability of Economic and Social Rights: The Indian Experience' in *Circle of Rights* (Washington D. C.: International Human Rights Internship Program, 2000).
 - 22 See *Francis Coralie Mullin v. The Administrator, Union Territory of Delhi* 2 SCR 516 (1981) concerning detention conditions and *Parmanand Katara v. Union of India* 4 SCC 286 (1989) regarding the obligation of the state to provide emergency medical treatment.
 - 23 The petitioner had been taken to a succession of eight state medical institutions ranging from a local health centre to two medical colleges and was refused treatment at each, either due to lack of beds or lack of technical capacity. Eventually he was admitted to a private hospital where he had to pay for treatment. See also *State of Punjab & Ors v. Mohinder Singh Chawla Etc* [1996] INSC 1666 in which the Supreme Court held that where certain medical treatment is not available in some states, and the patient is being treated at government expense outside his state, the latter should bear the costs of renting the room.
 - 24 *Paschim & Ors v. State of West Bengal & Anor* (1996) AIR SC 2426 at 2429.
 - 25 This included hospitals and emergency provision (ambulances and communications) by formulating a blueprint for primary health care with particular reference to treatment of patients under an emergency as part of the state's public health obligation under Article 47.
 - 26 *Consumer Education and Research Centre v. Union of India* 3 SCC 42 (1995) finding that no breach of the Constitution was incurred by reducing some employees' entitlements to medical benefits.
 - 27 See in particular *Mehta v. Union of India* 6 SCC 9 (1999) where the Supreme Court, after appointing an expert committee to formulate a detailed policy on conversion from petrol to cleaner fuels for vehicles in heavily polluted Delhi and incorporating its recommendations, issued several time-bound directions for conversion.
 - 28 For example, in *Dr Mohiuddin Farooque v. Bangladesh & Ors* (No. 1) 48 DLR (1996) HCD 438 the Bangladeshi Supreme Court, upon finding that a consignment of powdered milk, imported by a company, exhibited in some cases a radiation level above the acceptable limit, upheld the claim that the actions of government officers in not compelling the importer to send the consignment back to the exporter had violated the constitutional right to life of people who were potential consumers. Where lives were threatened by a man-made hazard then the state could be compelled by the court to remove the threat (unless justified by law) even where its primary DPSP obligation under Art 18 to raise the level of nutrition and improve public health could not be enforced. See also *Zima v. WAPDA* PLD 1994 SC 693 in which the Supreme Court of Pakistan, relying on the rights to life and dignity, which included the right to live in a clean environment, held that the local power authority, prior to constructing a potentially health threatening electricity grid station had to carry out a full consultation process with the affected community.
 - 29 In *Shortland v. Northland Health Ltd* [1998] 1 NZLR 433 the Court of Appeal, generously inter-

- preting the right to life as protected by Article 8 of the Bill of Rights, and drawing on the equivalent international provision – Article 6 of the International Covenant on Civil and Political Rights (ICCPR) ratified by New Zealand – was able to assess whether a clinical decision to withdraw dialysis treatment amounted to a breach of the Bill of Rights. In so doing the court recognized that section 151 of the *Crimes Act 1961* placed a legal duty on the local health authority to supply the patient with “the necessities of life” and that a failure to perform that duty “without lawful excuse” could lead to criminal responsibility. The Court noted that this positive duty was related to the right to life as guaranteed by Article 6(1) of the ICCPR and the understanding of that provision as elaborated by the United Nations Human Rights Committee in its General Comment 6. On the facts, the Court held that the consideration of a patient’s condition by the clinical team which had knowledge of his condition and his ability to benefit from dialysis, meant that there was a bona fide decision that the cessation of treatment was in the patient’s best interests. Consequently, Northland Health could not be said to be in breach of its duty to provide the necessities of life, and therefore the decision to withdraw dialysis was not objectionable and would not deprive the patient of his right to life. In so doing it recognized that judges were concerned with the lawfulness of the decision to discontinue dialysis, and not with the likelihood of the effectiveness of the treatment (cf. South African decision of *Soobramoney* discussed above).
- 30** See for example decisions such as *Corbiere v. Canada* [1999] 2 SCR 203 and *M v. H* 2 SCR 203 [1999]. This approach has been criticized by the leading Canadian constitutional commentator Peter Hogg as “vague, confusing and burdensome to claimants”: Peter Hogg, *Constitutional Law of Canada* (Toronto: Carswell, Student Edition, 2002) at 1059.
- 31** *Eldridge v. British Columbia* 3 SCR 624 [1997] where deaf individuals successfully challenged the failure of a provincial government to provide sign-language interpreters as part of its publicly funded healthcare system.
- 32** *Ibid.*, para. 73.
- 33** The rights to education (Article 2 Protocol 1) and property (Article 1 Protocol 1) are the only economic and social rights explicitly protected under the European Convention on Human Rights and thus under the Human Rights Act 1998.
- 34** Although the UK has ratified the ICESCR, together with a number of other major UN human rights treaties, it has yet to incorporate this treaty into national law.
- 35** One arguable exception was the holding by the Court of Appeal that given the decision to refuse the breast cancer drug Herceptin to the applicant was a life or death decision (without confirming whether Article 2 of the ECHR was engaged or not) the decision should be subject to rigorous scrutiny (*Rogers, R (on the application of) v. Swindon NHS Primary Care Trust & Anor* [2006] EWCA Civ 392, at para. 56). Both the European Commission and Court of Human Rights have held that Article 2 ECHR can be engaged in healthcare cases (see *X v. Ireland* 7 DR 78 (1976); *Association X v. UK* 14 DR 31 (1978) and *LCB v. UK* 27 EHRR 212 (1998)).
- 36** *Watts, R (on the application of) v. Bedford Primary Care Trust & Ors* [2003] EWHC 2228 para 45. However, the Court went on to hold that in the light of the Court of Appeal decision *R v. North West Lancashire Health Authority ex p A* [2000] 1 WLR 977, Article 8 imposes no positive obligations to provide medical treatment and that the pain and suffering endured by the applicant in not receiving treatment was not sufficiently serious to engage Article 3. Although the applicant was not able to succeed using human rights law he was able to on the basis of European Community law. Nevertheless, it appears unlikely until *R v. North West Lancashire Health Authority ex p A* is overruled that claims for meeting medical treatment costs based solely on human rights arguments will succeed.
- 37** *Goldsmith, R (on the application of) v. London Borough of Wandsworth* [2004] EWCA Civ 1170. The Court concluded inter alia that the decision-making process had not acted in the best interests

of the patient in securing her health, together with a complete failure to take into account her Article 8 rights, thereby recognizing that a patient's right to respect for her private life does not cease upon her entering a healthcare institution.

- 38** Two other cases were joined in the hearing: *R v. Secretary of State for the Home Department ex p Tesema* and *R v. Secretary of State for the Home Department ex p Adam (FC)*.
- 39** Applying *R (Q) v. Secretary of State for the Home Department* [2004] QB 36 the House of Lords held it was not necessary for the claimant to show the actual onset of severe illness or suffering for a claim to be established. If the evidence established clearly that charitable support in practice was not available, and that he had no other means of fending for himself, the presumption would be that severe suffering would imminently follow. The majority of the court recognized that the correct approach was one of prevention rather than "wait and see" which could result in the victim having to endure unnecessary suffering before upholding a claim.
- 40** [2005] UKHL 31.
- 41** The Lords distinguished the European Court of Human Rights decision of *D v. UK* 24 EHRR 423 (1997), relied on by the appellant, on the grounds that the situation in the receiving state was not as extreme as that faced by a terminally ill patient

in that case, where there was no prospect of any medical care or family support.

- 42** At para. 94. The high threshold approach has also been confirmed in relation to the right to private and family life under Article 8 ECHR. In *Dbeis and Ors v. Secretary of State for the Home Department* [2005] EWCA Civ 584 the Court of Appeal ruled that a failed asylum-seeker and her son suffering from cerebral palsy did not meet the exceptional test under Article 8 to prevent her being returned to her country of origin where there were adequate medical and education facilities.
- 43** At para. 92.
- 44** *N v. UK* (26565/05) para 42.
- 45** *Supra* n.41.
- 46** See also *ZT v. Secretary of State for the Home Department* [2005] EWCA Civ 1421 where the Court of Appeal adopted a similar approach in refusing an HIV positive Zimbabwean leave to remain. ZT's lawyers unsuccessfully sought to distinguish N on the grounds that the Zimbabwe regime had deliberately destroyed much of the medical infrastructure of the country through its economic policies. In *Razgar, R (on the Application of) v. Secretary of State for the Home Department* [2004] UKHL 27 the House of Lords recognized that Article 8, safeguarding respect for private and family life, could also be engaged by such cases but rejected the claim on the facts.

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