Progressive Realisation of the Right to Health: An Opportunity for Global Development

By Sheikh Mohammad Towhidul Karim[1] and George F Tomossy[2]

I. Introduction

The Right to Health has been recognised as a core socioeconomic right under international law since the proclamation of the Universal Declaration of Human Rights. As Gostin and Meier rightly note, "human rights have become a cornerstone of global health governance, foundational to contemporary policy discourses, programmatic interventions, and public health advancements."[3] The centrality of health promotion in global health policy is also readily apparent from the third Sustainable Development Goal of the United Nations' "2030 Agenda for Sustainable Development" (2015) – Good Health and Wellbeing – which states that "ensuring healthy lives and promoting the wellbeing of all ages is essential to sustainable development." Nevertheless, the degree to which a "right to health" is implicitly or explicitly contained within that framework is a matter for debate, with resulting implications for its enforcement.[4] Ambiguities in its meaning and scope have arguably impeded the development of health systems, which in many countries remain inequitable, poorly funded, unsafe and regressive.[5] On the other hand, extensive efforts by national and international policy makers, courts, international organisations, nongovernmental organisations and other stakeholders have been remarkably successful in promoting the goal of achieving the highest attainable standard of health.

This article examines the development of the concept of a right to health in order to improve understanding of the concept and provide guidance for policy makers and legislators in order to enable more effective protection and implementation of the right. It will examine the right to health from four approaches: theoretical and philosophical conceptions; the international legal framework; enforcement obligations of states; and a pragmatic notion of progressive realisation.

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1 PhD Candidate, Macquarie Law School, Macquarie University, Sydney, Australia; Assistant Professor, Department of Law, International Islamic University Chittagong, Bangladesh.

2 Senior Lecturer, Macquarie Law School, Macquarie University, Sydney, Australia. E-mail: George.Tomossy @mq.edu.au.

3 LO Gostin and BM Meier, 'The origins of human rights in global health' in BM Meier and LO Gostin (eds), *Human Rights in Global Health: Rights-Based Governance for a Globalizing World* (OUP 2018) 21.

4 CE Brolan and others, 'Did the right to health get across the line? Examining the United Nations resolution on the sustainable development goals' (2017) 2(3) BMJ Global Health e000353.

5 G Schmets, D Rajan and S Kadandale (eds), Strategizing National Health in the 21st Century: A Handbook (WHO 2016) 29; WHO, Everybody's Business-Strengthening Health Systems to Improve Health Outcomes: WHO's framework for action (WHO 2007) 1.

II. Theoretical and Philosophical Perspectives on the Right to Health

Although the concept of a right to health is frequently pitched at the international level, it remains problematic both within the international community and for individual states with regard to its scope and meaning. Whilst much of the debate revolves around a state's ability to protect, guarantee and enforce the right to health, many scholars have commented that a right to health is rarely self-evident.[6] Regardless, under the framework of the UN Sustainable Development Goals, health as physical and mental wellbeing becomes an important indicator of the success for governments in providing for the needs of their people.

Health has been recognised in various human rights instruments and defined as a desirable human condition, vital to the social and political good.[7] Simply put, health means "the art and the science of preventing disease, promoting health, and extending life through the organised effort of society".[8] A more holistic approach enunciated in the preamble to the Constitution of the World Health Organization provides that "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Moreover, a right to health would embody the entitlement to live in a physical and social environment that is conducive to leading a full and healthy life, including access to health services.[9]

In light of such an expansive conception of "health," linking across all aspects of human existence, a right to health becomes one of the most fundamental human rights.[10] Moreover, "health" should be maximised. As expressed in Article 14(2) of the UNESCO Universal Declaration on Bioethics and Human Rights (2005), "the enjoyment of the highest attainable standard of health" comprises a fundamental right of all citizens irrespective of their race, colour, religion, and political affiliation, economic or social condition. A myriad of social, political and philosophical factors have thus contributed to framing the right to health. For example, it has been observed that the notion of human rights was particularly developed during the ideological war between the East (focused on economic, social and cultural rights) and the West (focused on civil and political rights) during the Cold War period.[11] Hence, the Universal Declaration of Human Rights adopted civil and political rights as well as economic, social and cultural rights for the protection and promotion of human rights for all.

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6 VA Leary, 'The right to health in international human rights law' (1994) 1(1) Health and Human Rights 24; SB Shah, 'Illuminating the possible in the developing world: guaranteeing the human right to health in India' (1999) 32(2) Vanderbilt Journal of Transnational Law 435; K Tomasevski, 'Health' in O Schachter and CC Joyner (eds), *United Nations Legal Order*, Vol. 2 (Cambridge University Press 1995) 873; DP Fidler, 'International law and global public health' (1999) 48 University of Kansas Law Review 1.

7 SB Shah, 'Illuminating the possible in the developing world: guaranteeing the human right to health in India' (1999) 32(2) Vanderbilt Journal of Transnational Law 435, 455.

8 D Acheson, *Independent inquiry into inequalities in health report* (The Stationery Office 1998) 1; T Evans, 'A human right to health?' (2002) 23(2) Third World Quarterly 197.

9 T Evans, 'A human right to health?' (2002) 23(2) Third World Quarterly 197.

10 The Constitution of the World Health Organization, opened for signature 22 July 1946 (entered into force 7 April 1948) World Health Organization, New York; The Committee on Economic, Social and Cultural Rights, *CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health*, 22nd Sess, UN Doc E/C.12/2000/4 (11 August 2000).

11 J Donnelly, *Universal Human Rights in Theory and Practice* (Cornell University Press 2013); S Skogly, *Beyond National Borders: States' Human Rights Obligations in International Cooperation* (Intersentia 2006).

Exploring philosophical ideas about the right to health is helpful to counter scepticism regarding the right in international law.[12] With significant disagreement amongst scholars and policy makers about its enforceability, some claim that the right to health is a positive right whilst others maintain that it is a negative right. The positive conception of a right to health evolved in the nineteenth century when public health reformers and human rights activists advocated for government involvement in the development of a public health system.[13] Objections focusing on a normative view of rights and obligations, however, proposed that in the absence of a readily identifiable duty-bearer or specific set of obligations, the right to health could not provide the basis for a coherent policy.[14] Although the right to health, like other economic and social rights, should be recognized and treated as a universal human right, the justification for abstract rights is often "muddled" or "vague" because of a perceived failure to properly allocate the obligations necessary to realize such rights.[15] On the other hand, this position has been rebutted on the basis that it fails to make a reasonable attempt to interrogate the text of the international treaties on the right to health to evaluate the nature of a state's obligations.[16]

In terms of enforcement, the international community, including major donors and drug companies, would become the duty-bearers appointed to secure the right to health.[17] Such an approach gains traction with views that would set limits on the positive duty of the state in terms of an obligation to protect individual health against threats that were beyond their capacity to control.[18] Further, the right to health can be conceptualised not simply an abstract moral ideal, but rather as a "meaningful and operational right" that must be justiciable and enforceable under international law.[19] This approach imposes correlate obligations on both state and non-state actors to protect and promote health, demonstrating that progressive realisation of the right to healthcare will not be manifest without "individual and societal commitments to public moral norms."[20] Hence, the state, international community and non-state actors are all important in order to full realisation of the right to health.

In general, human rights including the right to health can be viewed as a set of norms based on ethical principles incorporated into national and international legal systems with a view to regulating the actions of states and non-state entities (individuals and groups).[21] Theoretically, the right to health is a vital socioeconomic right that provides a normative framework for political

12 J Tobin, *The Right to Health in International Law* (OUP 2012).

13 ED Kinney, 'The international human right to health: what does this mean for our nation and world? (property, wealth and inequality)' (2001) 34(4) Indiana Law Review 1457.

14 G Sreenivasan, 'II – Gopal Sreenivasan: a human right to health? Some inconclusive scepticism' (2012) 86(1) Aristotelian Society Supplementary 239; O O'Neill, 'The dark side of human rights 1' (2005) 81(2) International Affairs 427.

15 O O'Neill, 'The dark side of human rights 1' (2005) 81(2) International Affairs 427.

16 J Tobin, *The Right to Health in International Law* (OUP 2012).

17 J Wolff, 'The demands of the human right to health' (2012) 86(1) Proceedings of the Aristotelian Society Supplement 217.

18 HT Engelhardt, *The Foundations of Bioethics* (OUP 1996); J Tobin, *The Right to Health in International Law* (OUP 2012).

19 JP Ruger, *Health and Social Justice* (OUP 2010).

20 JP Ruger, *Health and Social Justice* (OUP 2010).

21 SP Marks, 'The emergence and scope of the human right to health' in J M Zuniga, S P Marks and L O Gostin (eds), *In Advancing the Human Right to Health* (OUP 2013).

commitment as well as a lens through which states can make decisions when balancing competing interests.[22] A capability approach provides an important tool to develop the right to health in international healthcare policy. For example, gender equality linked to health equality can provide a normative and evaluative framework for promoting social justice whereby empowering women is necessary for achieving public health goals,[23] including "to reduce child neglect and mortality, to decrease fertility and overcrowding and more generally to broaden social concern and care".[24] The expansion of an individual's capabilities – real opportunities and freedom that people have to do and to be – should be the absolute aim of public policy.[25] Health is a critical element in the development process, with good health and economic growth supporting each other in parallel. Improving health is a necessary part of a country's development and a healthy population is a vital part of economic prosperity.

Nevertheless, a common tendency of many scholars is to view socioeconomic rights as merely aspirational.[26] The right of liberty, for example, is fundamental and universal, and can, therefore, be justified without reference to any covenants or institutions; but rights to goods and services are special or institutional rights that can only be justified after signing and ratifying covenants. Under this conception, it is difficult to claim that human rights and obligations form corollary normative claims, with the default position rejecting the idea of human rights as prescriptive or normative and thus see the claim of human rights as aspirational.[27]

In contrast, the UNDP emphasised that socioeconomic rights, including healthcare, are not merely aspirations:

> […] health care and other social and economic achievements are not just development goals. They are human rights inherent in human freedom and dignity. But these rights do not mean an entitlement to a handout. They are claims to a set of social arrangements – norms, institutions, laws, an enabling economic environment – that can best secure the enjoyment of these rights. It is thus the obligation of governments and others to implement policies to put these arrangements in place.[28]

22 JP Ruger, 'Toward a theory of a right to health: capability and incompletely theorized agreements' (2006) 18(2) Yale Journal of Law & the Humanities 273; A Sen, 'Why and how is health a human right?' (2008) 372(9655) The Lancet 2010; M Kavanagh, 'The right to health: institutional effects of constitutional provisions on health outcomes' (2016) 51(3) Studies in Comparative International Development 328.

23 A Sen, 'Gender inequality and theories of justice' in M Nussbaum and J Glover (eds), *Women, Culture and Development: A Study of Human Capabilities* (OUP 1995); see also M Nussbaum, 'Capabilities as fundamental entitlements: Sen and social justice' in B Agarwal, J Humphries and I Robeyns (eds), *Amartya Sen's Work and Ideas: A Gender Perspective* (Routledge, 2005) 35.

24 A Sen, 'The many faces of gender inequality' *The New Republic* (New York, 17 September 2001) 35, 39.

25 A Sen, *Commodities and Capabilities* (North Holland 1985); M Fox and M Thomson, 'Realising social justice in public health law' (2013) 21(2) Medical Law Review 278.

26 J Griffin, 'Discrepancies between the best philosophical account of human rights and the international law of human rights' (2001) 101(1) *Proceedings of the Aristotelian Society* 1-28; O O'Neill, 'The dark side of human rights 1' (2005) 81(2) International Affairs 427, 432.

27 O O'Neill, 'The dark side of human rights 1' (2005) 81(2) International Affairs 427, 432.

28 UNDP, 'Human development report 2000 – human rights and human development' (United Nations Development Programme 2000).

The notion that human rights and health are inseparably connected as normative and binding matters[29] provides an important dimension to understanding the right to health. For example, compulsory detention of a person suffering from a disease without a public health justification would certainly violate both the freedom of movement and the right to health because the detention serves no reasonable public health purpose.[30] It is thus viable, under international law, to replace the dichotomy of "negative" or "positive" human rights with an approach that holds that each right, whether civil and political right or economic, social and cultural right, creates a series of governmental obligations to respect the right from any direct infringement.[31] Thus, although substantial scepticism about the theoretical or philosophical conception of a right to health may remain, including whether it is a positive or negative right, a normative foundation nevertheless exists to support implementation of a right to health for the welfare of all human beings.

III. The Right to Health within an International Legal Framework

In addition to having a viable theoretical foundation, the right to health possesses legal identity by virtue of the "International Covenant on Economic, Social and Cultural Rights 1966" (ICESCR) and other relevant international treaties. The right to health has been extended to many countries through international treaties and conventions.[32] Although international documents on health proclaim the right to health in different ways, such as a "standard of living adequate for health," "the highest attainable standard of physical and mental health" or the "right to healthcare," the main theme of all these attempts is actually the establishment of a system of health opportunity and equality for everyone. It is noted that international instruments are not only concerned with the right to health, but also several health-related issues. This means that definite improvements in the right to health will ultimately be reflected in improvements in other areas such as public health and healthcare services. Most provisions of international right to health instruments formulate member state obligations with regard to a broad range of health-related issues that include healthcare, reproductive health, occupational, environmental and child health.[33]

As a legal concept, the history of the right to health dates back many decades. The constitution of the WHO first proclaimed the right to health in 1946. WHO regulations came into force automatically for all member states after due notice had been given of their adoption by the World Health Assembly, except for members that duly notified the Director General of rejection or reservations. Two years later after the adoption of the WHO constitution, the Universal Declaration of Human Rights was adopted by the General Assembly of United Nations following the horrific

29 R Pangalangan, 'The Domestic implementation of the international right to health: the Philippine experience' in JM Zuniga, SP Marks and LO Gostin (eds), *Advancing the Human Right to Health* (OUP 2013).

30 DP Fidler, 'International law and global public health' (1999) 48 University of Kansas Law Review 1.

31 AE Yamin, 'Taking the right to health seriously: implications for health systems, courts, and achieving universal health coverage' (2017) 39(2) Human Rights Quarterly 341.

32 The treaty bodies that monitor the actions of ICESCR 1966, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) 1979, the CRC 1989 have adopted general recommendations and general comments on the right to health and health-related issues. Apart from these treaties, many declarations, such as the Declaration of Alma-Ata 1978, the United Nations Millennium Declaration and Millennium Development Goals, the Sustainable Development Goals and the Declaration of Commitment on HIV/AIDS 2001 have also emphasized on the right to health and health-related issues.

33 CAT Bright and A Toebes, *The Right to Health as a Human Right in International Law* (Intersentia 1999) 4.

events of the holocaust during the Second World War. Article 25 of the UDHR is particularly important for health rights:

> 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 […].

In this spirit, many countries, including those in the European Economic Community and socialist countries, introduced free and easily accessible healthcare for their citizens.[34] The UDHR (1948) also emphasized the need to provide special care to those patients who were vulnerable such as pregnant women or children and also to provide special protection to children whether born in or out of wedlock.

The rights stated in the UDHR and other international documents are deliberately general in nature so as to ensure the widest consensus concerning the application of social, political, economic and cultural norms in a state.[35] Despite the universal nature of the UDHR, many considered it to be an aspirational document.[36] No member state has accepted or adopted the provisions of the UDHR in its full form.

The ICESCR, unlike the UDHR, was the first binding covenant to provide a conclusive formulation of the right to health. Article 12 states 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 […] assure to all medical service and medical attention in the event of sickness.

The ICESCR set out some important considerations for the full realisation of the right to health, including that governments are mandated to provide medical services to their citizens under Article 12 (2)(d). The United Nations Committee on Economic, Social, and Cultural Rights (CESCR), through General Comment No. 14 on "The Right to the Highest Attainable Standard of Health", stated that:

> Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity.

The CESCR and Office of the United Nations High Commissioner for Human Rights (OHCHR) both referred to a normative approach for developing fully accountable mechanisms for full realisation of the right to health.[37] Under this approach, the right to health depends on and is necessary for the

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34 YM Barilan and M Brusa, 'Human rights and bioethics' (2008) 34(5) Journal of medical Ethics 379.

35 JT Eberl, ED Kinney and MJ Williams, 'Foundation for a natural right to health care' (2011) 36(6) Journal of Medicine and Philosophy 537.

36 M Robinson, Realizing Human Rights: Take Hold of it Boldly and Duly, Oxford University Romanes Lecture (11 November 1997); S Yecies, 'Sexual orientation, discrimination, and the universal declaration of human rights' (2011) 11(2) Chicago Journal of International Law 789.

37 VFL Schieck, 'Towards the full realization of the human right to adequate food and nutrition' (2015) 57(2) Development 155; OHCHR and WHO, 'The Right to Health', Fact Sheet No. 31 (OHCHR and WHO 2008); WHO, 'Leading the realization of human rights to health and through health: report of the high-level working group on the health and human rights of women, children and adolescents (WHO 2017).

realisation of other human rights, including both freedoms and entitlements. However, the right to health was not to be understood as a right to be healthy. The stated freedoms include the right to control one's own health, including sexual and reproductive freedom, and the right to be free from interference, such as non-consensual medical treatment, torture and experimentation. The entitlements refer to equality-based health systems designed so that all people may enjoy the highest attainable standard of health.[38] In Comment 14, the Committee explained its practical approach to promote the right to health and also recognised that this right imposed general, not individual, obligations on governments. The committee's goal is for member states to adopt and implement policies tailored for their own populace.[39] Thus, states need to ensure four interrelated principles of the right to health: availability, accessibility, acceptability and quality of healthcare facilities, goods and services for their citizens.[40] The guidelines for how to respect, protect and fulfil the right to health provided in this Comment can be looked upon as a comprehensive blueprint for how governments can best legislate effective policies and implement them satisfactorily. The CESCR specifies the duties and obligations of member states to provide and promote healthcare facilities to all and treats other health-related issues in an equitable and non-discriminatory manner, particularly for the most vulnerable and marginalised groups in the population. According to this Comment, the obligations of member states encompass both technical and legal obligations. Preparing a national action plan for healthcare services and designing benchmarks and indicators for monitoring progress, as well as educating people who participate in health decisions, are all technical obligations. On the other hand, legal obligations must also be met for policy adoption and implementation by the member states in order to ensure health rights and address underlying determinants of health.

Interpretation of the right to health, as proclaimed by the CERD, not only includes providing timely and appropriate healthcare to individuals, but also spells out the underlying determinants of health, such as access to safe and clean drinking water, effective sanitation facilities, healthful occupational and environmental conditions, an adequate supply of safe, nutritious food, appropriate housing and access to health-related education and information.[41] It also guarantees that medical treatment shall be non-discriminatory and non-coercive, and that entitlements, such as the right to essential primary healthcare,[42] will be maintained. Physicians for Human Rights recommends that policies for the right to health can best be achieved through a combination of skilled healthcare workers and access to essential medications, as well as through the underlying determinants

38 The Committee on Economic, Social and Cultural Rights, *CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health*, 22nd Sess, UN Doc E/C.12/2000/4 (11 August 2000) para. 8; OHCHR and WHO, 'The Right to Health', Fact Sheet No. 31 (OHCHR and WHO 2008).

39 The Committee on Economic, Social and Cultural Rights, *CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health*, 22nd Sess, UN Doc E/C.12/2000/4 (11 August 2000) para. 18, 33, 35, 36.

40 OHCHR, *Health Policy Makers: Summary Reflection Guide on a Human Rights-Based Approach to Health* (United Nations 2015).

41 The Committee on Economic, Social and Cultural Rights, *CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health*, 22nd Sess, UN Doc E/C.12/2000/4 (11 August 2000) para. 11; P Hunt, 'The human right to the highest attainable standard of health: new opportunities and Challenges' (2006) 100(7) Transactions of the Royal Society of Tropical Medicine and Hygiene 603.

42 The Committee on Economic, Social and Cultural Rights, *CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health*, 22nd Sess, UN Doc E/C.12/2000/4 (11 August 2000) para. 8.

mentioned above.[43] An effective, accountable, integrated healthcare system of good quality is, without doubt, the minimum requirement for the realisation of a right to health.[44]

The Human Rights Commission (renamed as the Human Rights Council in 2006) established the post of UN Special Rapporteur in 2002 to ensure that states ensure the highest attainable standards of physical and mental health. Since then, it has gathered, requested, received and exchanged health information from all relevant sources, and discussed information with relevant stakeholders, such as governments, UN bodies, the WHO, NGOs and international financial institutions. It also recommends that UN member states adopt laws and policies for the promotion and protection of the right to health. In 2010, the Special Rapporteur of the Human Rights Council gave special attention to issues dealing with the elder population, gender identity, disabilities, AIDS, health systems and millennium development goals.[45] In the same year, the United Nations General Assembly recognised "the right to safe and clean drinking water and sanitation as a human right that is essential for the full enjoyment of life and all human rights".[46]

IV. State Obligation for the Realisation of a Right to Health

International human rights law lays out both moral and legal obligations of member states to protect and promote the health of their citizens. Whilst the Universal Declaration of Human Rights sets out the moral obligations of member states, the ICESCR and ICCPR impose binding legal obligations. States are obliged to respect the provisions of covenants in terms of implementation, including submission of periodic compliance reports to concerned committees.[47] Between the two covenants, the ICESCR furnishes comprehensive, global protection today under international law for the establishment of the right to health. For example, according to Article 10 of the ICESCR, member states are responsible for arranging special protection to mothers during a reasonable period before and after childbirth and ensuring paid leave for them as employees. States are also required to take special measures and pass laws for the protection of the occupational health of employed people.

Significantly, Article 2 of the ICESCR imposes legal obligations on member states based on their available resources, including taking effective steps to enact domestic legislation to implement the right to health. A member state must implement such rights by maximal use of their resources, which depends on proper resource allocation and effective policy decisions by government agencies. Thus, the implementation of the right still remains dependent on state policy

43 WHO, *Physicians for Human Rights: About the Global Health Action Campaign* (WHO, 2009).

44 P Hunt and G Backman, 'Health systems and the right to the highest attainable standard of health' (2008) 10(1) Health and Human Rights 81.

45 Human Rights Council, *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, 15th Session, UN Doc A/HRC/RES/15/22 (6 October 2010).

46 *The Human Right to Water and Sanitation*, GA Res 64/292, UN GAOR, 64th Sess, 108th plen mtg, Agenda Item 48, UN Doc A/RES/64/292 (28 July 2010). UNGA, Resolution 64/292, "The Human Right to Water and Sanitation," July 28, 2010. Article 24 of the CRC and Article 14 of the CEDAW both expressly recognize the right to water.

47 *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) Article 16; *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976) Article 40.

and available resources, which may be constrained by domestic socioeconomic and political priorities.[48]

Consequently, achieving this goal is not straightforward as there are no prescribed rules or specific systems for enforcement by states to secure rights enunciated in the ICESCR. It merits noting that General Comment 3 of the CESCR explained that Article 2, paragraph 1 of the ICESCR regarding the nature of the member states' obligations, outlines the minimum obligations, which are incumbent upon member states under the ICESCR. Accordingly, states have an obligation to satisfy the minimum essential levels of each of the rights described in the covenant. If a significant number of individuals are deprived of primary healthcare by a member state, it would be considered prima facie evidence that the state has failed to discharge its obligations under the Covenant. In such a circumstance, the state's requirements for ensuring the right to health, like other human rights, can be examined by three levels of obligation: the obligation to respect, the obligation to protect and the obligation to fulfil as enunciated in General Comment 14 of the CESCR. In order to do so, the CESCR spells out the main obligations and activities that states have to carry out to guarantee minimal adherence to the Comment with regard to the right to health. Indeed, it has been argued that states have a duty to guarantee the right to health expressed as a minimum core obligation under international law, with judicial adherence through the interpretation of domestic and international law playing a critical role in ensuring state compliance.[49] Whilst many countries, such as the USA, Australia, UK, India and Bangladesh, consider the right to health as nonjusticiable (not enforceable),[50] judicial intervention in many low- and middle-income countries has significantly expanded the justiciability of the right by interpreting constitutional provisions and recognising the right.[51]

These obligations and institutional activities encourage member states to prepare health policies for healthcare and protection, develop built-in indicators, introduce monitoring systems for healthcare and engage individuals and the community in health-related issues. Member states are thereby required to:

1. adopt framework legislation setting out a national strategy and plan of action, and earmarking sufficient resources to carry out the plan;
2. identify the appropriate right to health indicators and benchmarks; and
3. establish adequate remedies and accountability – for example, access to courts, ombudsmen or human rights commissions.[52]

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48 SD Jamar, 'The international human right to health' (1994) 22(1) Southern University Law Review 1; AL Taylor, 'Making the world health organization work: a legal framework for universal access to the conditions for health' (1992) 18(4) American Journal of Law and Medicine 301.

49 SMT Karim and others, 'Judicial adherence to the minimum core obligation of a right to health in Bangladesh: a critical review' (2019) 20(1) Asia Pacific Journal on Human Rights and the Law 131.

50 G Backman and others, 'Health systems and the right to health: an assessment of 194 countries' (2008) 372(9655) The Lancet 2047.

51 S Gloppen, 'Litigation as a strategy to hold governments accountable for implementing the right to health' (2008) 10(2) Health and Human Rights 21; AE Yamin and O Parra-Vera, 'Judicial protection of the right to health in Colombia: from social demands to individual claims to public debates' (2010) 33(2) Hastings International and Comparative Law Review 431.

52 LO Gostin, 'The human right to health: a right to the highest attainable standard of health' (2001) 31(2) The Hastings Centre Report 29.

Due to contemporary human rights obligations, discourse and practice, many states have recognised the right to health as a fundamental right through their national constitutions and laws. The global trend of recognition through constitutional reform is gradually increasing. Only 17 percent of written constitutions of the world expressly declared the right to health in 1970,[53] but the number had increased to 51 percent by 2010. Likewise, domestic laws were recently found to guarantee the right to medical care services in 100 UN member states.[54]

Many countries have incorporated a right to health directly or indirectly in their national constitutions. For example, the Constitution of Brazil (1988) guarantees the right to health under Article 196 that "health is the right of all and a duty of the State and shall be guaranteed by means of social and economic policies aimed at reducing the risk of illness […]" A similar provision is incorporated in the Constitution of the Republic of Haiti (1987) whereby there is an "absolute obligation to guarantee the right to life, health, and respect of the human person (Article 19)." In contrast, the constitution of Bangladesh indirectly provides direction for the progressive realisation of tangible health rights by making the government accountable for the provision of health services.[55]

The laws, policies and institutional practices of the WHO promote opportunities for people to lead healthy lives,[56] but establishing a legal basis for the right to health is essential to buttress a range of economic, social, physical, organisational, instructional, administrative, management and other supportive factors. In a Note to the UN General Assembly in 2003, the General-Secretary reinforced the relationship between health promotion and determinants of health,[57] and that a failure to address the aforementioned factors or inequalities is detrimental to health. Poverty and political strife present severe impediments to healthy living. For example, the mortality rate among children under the age of 5 per 1,000 live births in Somalia was 127 whereas in Finland it was only 2.[58] Somalia's right to health legislation was enacted recently in 2012 while the right to health in Finland has been part of its constitution since 1919. Sweden introduced a new public health strategy, which included 11 policy domains; and among those 5 policies were related to social determinants of health, namely, active participation in healthcare equality, healthier working conditions, economic and social security, environmental policy and children and adolescent's

53 M Kavanagh, 'The right to health: institutional effects of constitutional provisions on health outcomes' (2016) 51(3) Studies in Comparative International Development 328.

54 J Heymann and others, 'Constitutional rights to health, public health and medical care: the status of health protections in 191 countries' (2013) 8(6) Global Public Health 639; R Dittrich and others, 'The international right to health: what does it mean in legal practice and how can it affect priority setting for universal health coverage?' (2016) 2(1) Health Systems & Reform 23.

55 *The Constitution of the People's Republic of Bangladesh* (Bangladesh, 2014 last amendment) Article 16, 18; SMT Karim and others, 'Judicial adherence to the minimum core obligation of a right to health in Bangladesh: a critical review' (2019) 20(1) Asia Pacific Journal on Human Rights and the Law 131.

56 WHO, 'Ottawa charter for health promotion' (1986) 1 Health Promotion i.

57 There are multiple and interactive factors, such as personal, social, economic and environmental which influence health and determine the health status of individuals or communities. See WHO, 'WHO Health Promotion Glossary. WHO Collaborating Centre for Health Promotion', Department of Public Health and Community Medicine (University of Sydney 1998).

58 J Quinn, 'Report 2018: estimates developed by the UN inter-agency group for child mortality estimation' Levels and Trends in Child Mortality (The United Nations Children's Fund 2018).

health.[59] In like fashion, the UK placed emphasis on the reduction of health inequalities in order to develop a comprehensive, inclusive health policy.[60] At present, both countries' health status is good according to the World Bank.[61]

Although international treaties impose legal obligations on states, such obligations are not always mandatory. In order to assess the actual legal obligations of a particular state, it is necessary to ascertain whether that state has registered any reservations against international treaties. Reservation clauses added before signing can allow state agencies to keep certain rights under Article 1(d) of the "Vienna Convention on the Law of Treaties" in order to exclude or modify the legal effects of certain provisions of the treaty. However, UN members are not allowed to enter into any reservations under that convention unless it is accepted by other member states or is not contrary to the object and purpose of the treaty. Hence, it becomes clear that while member states may have an obligation to implement a right to health under international law, various legal mechanisms as well as pragmatic considerations may limit the extent to which implementation can be achieved.

V. Progressive Realisation of the Right to Health

Progressive realisation is defined as the development of socioeconomic rights wherein each state has a duty to examine its existing barriers in legal, administrative, operational and financial terms, and to take necessary steps to ensure peoples' rights.[62] Article 2(1) of the ICESCR directs each member state to take necessary steps for the progressive realisation of socioeconomic rights, such as the right to health, within the limits of available resources. This directive has generated some confusion in how state parties are supposed to determine when the maximum level of rights has been ensured within their available resources. This vagueness affords flexibility to state policy makers in establishing their level of obligation to protect socioeconomic rights. Furthermore, the flexibility inherent in progressive realisation is useful in permitting a state to ensure socioeconomic rights over a longer period of time as a gradual process.[63] Indeed, as the Constitutional Court of South Africa observed in the "Grootboom case" and "Mazibuko case", it is not an easy task to determine the "minimum threshold for the progressive realization" of socioeconomic rights without identifying the reasonableness of such rights in a state.[64]

Access to resources is a leading determinant of a nation's ability to achieve the right to health progressively. Although resource availability gives flexibility to each state, the General Assembly of the UN recognized that, without sufficient resources, progressive realisation of healthcare rights

59 C Hogstedt and others, 'The Swedish public health policy and the national institute of public health' (2004) 32(64) Scandinavian Journal of Public Health 60; M Marmot, 'Social determinants of health inequalities' (2005) 365(9464) The Lancet 1099.

60 D Acheson, *Independent inquiry into inequalities in health report* (The Stationery Office 1998).

61 J Quinn, 'Report 2018: estimates developed by the UN inter-agency group for child mortality estimation' Levels and Trends in Child Mortality (The United Nations Children's Fund 2018).

62 S Verma, 'Justiciability of economic social and cultural rights: relevant case law' (2005) working paper, International Council on Human Rights Policy, Rights and Responsibilities of Human Rights Organisations, Geneva, March 15.

63 L Chenwi, 'Unpacking 'progressive realisation', its relation to resources, minimum core and reasonableness, and some methodological considerations for assessing compliance' (2013) 46(3) De Jure 275.

64 *Government of the Republic of South Africa & others v Grootboom & others* [2001] 1 SA 46 (Constitutional Court) para 32; *Mazibuko and Others v City of Johannesburg and Others* [2010] 4 SA 1 (Constitutional Court) para 60.

was impossible. Resources in this context do not only mean state resources, but also external advantages received from international sources as stated in paragraph 26 of the "Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights (Limburg Principles)" and paragraphs 3 and 38 of the CESCR General Comment Nos 3 and 14, respectively. According to the Convention on the Rights of the Child,[65] a state's resources must be understood to include human, organisational, technological and information resources as well as financial revenues that are essential for the realization of socioeconomic rights. In this regard, the meaning of "resources" must be considered in terms of practicality as outlined in Section 31 of the "Vienna Convention on the Law of Treaties."[66] Each state needs to examine its financial capital, human and other resources to allocate most effectively in practical terms for the progressive achievement of equitable and comprehensive healthcare. Nevertheless, paragraph 2 of General Comment 3 of the CESCR emphasised the crucial importance of initiating a definite set of "deliberate, concrete and targeted" steps for the timely realization of full health rights for all citizens.[67]

Although the notion of progressive realisation through sensible resource utilisation is relatively straightforward, there is still an ongoing debate about how to determine whether a member state has made progress considering its maximum available resources. In this regard, the United Nations' guidelines for state practices provide a useful framework for measuring ongoing achievements of each state, with indicators and benchmarks to measure progress and monitor stagnation or retrogression. The Committee provided guidelines in CESCR General Comment 14 for the adoption of appropriate indicators and benchmarks along the path to universal health.[68] According to the Comment, the national health strategy of a member state will determine the appropriate indicators and benchmarks. The main purpose of utilising indicators is to monitor a state's obligations as stated in Article 12 of the ICESCR. Having determined the necessary indicators, a state is required to set appropriate national benchmarks for measuring the status of each indicator in relation to the goals of providing fair and equitable healthcare to its citizens.[69] Subsequently, the UN General Assembly introduced three indicators for the right to health:[70] first, structural indicators, which address whether a state has key structures, systems and mechanisms in relation to human rights such as constitutionally entrenched rights to health, national human rights institutions, national health policies and plans of action, a government approved list of essential medicines and free drugs at primary public health facilities; second, process indicators, which monitor the effectiveness of actions implemented as part of health policy measures and programs, such as the percentage of pregnant women attended by skilled healthcare personnel for check-ups and the percentage of births attended by skilled birth attendants; and third, outcome indicators, which measure the results

65 *The Committee on the Rights of the Child Convention on the Rights of the Child*, Chapter VII, 46th Session, UN Doc CRC/C/46/3 (22 April 2008).

66 J Tobin, *The Right to Health in International Law* (OUP 2012).

67 The Committee on Economic, Social and Cultural Rights, *CESCR General Comment No. 3: The Nature of States Parties' Obligations*, 5th Session, UN Doc E/1991/23 (14 December1990).

68 The Committee on Economic, Social and Cultural Rights, *CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health*, 22nd Sess, UN Doc E/C.12/2000/4 (11 August 2000).

69 The Committee on Economic, Social and Cultural Rights, *CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health*, 22nd Sess, UN Doc E/C.12/2000/4 (11 August 2000) para. 57–8.

70 *The right of everyone to enjoy the highest attainable standard of physical and mental health*, Agenda item 117 (c), 58th Sess, UN Doc A/58/427 (10 October 2003).

achieved by health policies and programs, such as the number of maternal deaths per 100,000 live births, the number of perinatal deaths per 1,000 births and the percentage of men and women who are infected with HIV. Thus, the establishment of appropriate indicators and benchmarks constitutes a powerful system for monitoring and measuring progressive realisation of the right to health.

Each state should concentrate on the proper allocation of resources and not discriminate based on inequities.[71] In this respect, the Constitutional Court of South Africa remarked that a state "must accelerate reasonable and progressive schemes" to develop an appropriate healthcare environment for their citizens.[72] In addition, Article 25 of the "Limburg Principles" stated that member states are obligated to respect the right to a minimum level of health protection irrespective of their level of economic resources. In this context, a state's duty is to utilise maximum available resources.

It is recognised that: full realisation of a right to health cannot be achieved within a short period of time; gradual progress toward achievement is expected; and that the rate will be different for every state. Undoubtedly, the budgets and performance of developed countries will be better than those of developing countries; however, the rate of progress in achieving universal health advantages for the citizenry of each state must be "rational and reasonable." In order to determine what is rational and reasonable, states have to adhere to indicators and benchmarks defined by the General Assembly to measure their progress. For example, a state may take the initiative to reduce maternal deaths by 20–30 percent over the next five years within the limits of available resources. After five years, the state can measure achievement in accordance with this target. In addition, a state can introduce "retrogressive measures" to determine how well the utilisation of maximum available resources is supporting the progressive realization of health. Alternatively, a state can test its progress by judging whether its use of resources would be considered rational and reasonable. The use of retrogressive measures ensures that the current level of achievement cannot be reduced in subsequent years. For example, the public health budget of a state in a certain year cannot be less in the following year without justification of exceptional circumstances. This means that the CESCR prohibits the use of regressive policies to enhance people's rights to health.[73] Every state has to utilise its resources in the best possible way to maintain progress toward personal health.

It should also be noted that a country cannot avoid the minimum obligation to adopt a plan of action by claiming a lack of available resources.[74] Comments 3 and 14 of the CESCR described the minimum core obligations of a state to its people. The Committee decreed that a member state must observe "minimum core obligations" to ensure at least minimum essential levels of socioeconomic rights including healthcare.[75] To that end, CESCR General Comment 14 authorised

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71 The Committee on Economic, Social and Cultural Rights, *CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health*, 22nd Sess, UN Doc E/C.12/2000/4 (11 August 2000) para. 19.

72 *Minister of Health and Another v. New Clicks South Africa (Pty) Ltd and Others* [2006] 2 SA 311; *Minister of Health & others v. Treatment Action Campaign & others* [2002] 5 SA 721.

73 The Committee on Economic, Social and Cultural Rights, *CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health*, 22nd Sess, UN Doc E/C.12/2000/4 (11 August 2000).

74 The Committee on Economic, Social and Cultural Rights, *CESCR General Comment No. 11: Plans of Action for Primary Education*, 20th Session, UN Doc E/1992/23 (10 May 1999) para. 9.

75 See also SMT Karim and others, 'Judicial adherence to the minimum core obligation of a right to health in Bangladesh: a critical review' (2019) 20(1) Asia Pacific Journal on Human Rights and the Law 131.

the following six core obligations that every state needs to meet for providing the right to health for its population:[76]

1. non-discriminatory access to health facilities, goods and services;
2. access to the minimum essential safe and nutritious food;
3. access to basic shelter, housing and sanitation and safe and potable water;
4. essential drugs as defined by WHO;
5. equitable distribution of all health facilities, goods and services; and
6. adoption and implementation of a national public health strategy and plan of action.

As discussed earlier, the CESCR suggested in Comment 14 that national health policy should identify available resources and use those in the most appropriate way for the progressive realisation of the right to health. Otherwise, it will be treated as a violation of state obligations under Article 12 of ICESCR as enunciated in the same Comment. Hence, each state has to utilise the maximum available resources for progressing toward the essential right to health.

VI. Conclusion

Ultimately, progressive realisation of a right to health should be understood as a *process* to achieve incremental gains towards a vision of health and wellbeing. This acknowledges pragmatic resource limitations faced by states. Thus, in addition to the necessary monitoring of clear milestones or targets, progress *along* a reform pathway should itself provide an indicator of success for the purpose of evaluating state accountability in meeting human rights obligations. This might include, for example, successful implementation of legal or institutional frameworks that have been empirically demonstrated to lead to positive changes in practices, promotion of rights or other outcomes. Policy makers could then aim to develop strategies that focus on alternative or indirect institutional reforms, including by leveraging other policy initiatives. For example, 'wellbeing', as expressed by the United Nations Sustainable Development Goals in its *2030 Agenda*, can be reframed as a set of goals that are intrinsically linked to environmental goals through interconnected institutional structures;[77] and in so doing, can inspire policies that would achieve social outcomes in both areas by targeting those structures. By incorporating a broader range of strategies within evaluative frameworks, progressive realisation can thus be reframed as an opportunity to achieve incremental improvements rather than as a means to rationalise falling short of an aspirational goal in the face of limited resources.

While there is continued debate about the meaning, scope and enforceability of a right to health, with 'health' depending on several factors or underlying social or environmental determinants, this article maintains that states nevertheless have a positive obligation to ensure a right to health and promote the highest possible standard of health and wellbeing. Although a state's ability to implement strategies to meet the broad range of targets associated with a right to health is ultimately limited by the reality of available resources and competing national priorities, a pragmatic approach to promoting an right to health through progressive realisation provides a rational approach for policy makers and legal reformers. However, consistent with the trend internationally, entrenching

76 The Committee on Economic, Social and Cultural Rights, *CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health*, 22nd Sess, UN Doc E/C.12/2000/4 (11 August 2000).

77 J Waage and others (2015) 'Governing the UN Sustainable Development Goals: interactions, infrastructures, and institutions' *The Lancet Global Health* 3(5) e251–e252.

a right to health in domestic legal systems, whether through constitutional amendment or human rights legislation, should be the first step in those jurisdictions where explicit legal protection of the right to health remains absent.