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Introduction

In recent years the right to health has come into its own in terms of recognition by states, active promotion by key international organizations, grassroots level campaigns, and general scholarly engagement. This book recounts the historical, philosophical, and theoretical journey of the concept as a prelude to identifying its normative content and the nature of the obligations that flow from it.

One of the greatest challenges in undertaking such an assessment is to navigate between the extremes of great enthusiasm and optimism, manifested by many of the proponents of the right to health, and the deeply pessimistic views of those who doubt that the concept has sufficient traction in terms of coherence, definability, political viability, economic sustainability, or justiciability. This book mounts a strong defence of a middle course that sees the right to health as a concept that has matured dramatically over the past decade or two and holds immense promise as both a normative framework and an operational framework, but which will continue to confront many challenges of a legal, political, economic, and cultural nature.

The greatly enhanced visibility of the right to health over the past decade can be seen in many contexts—political, social, institutional, legal, medical, and academic. The end of Cold War created the opportunity for recognition of the interdependence and indivisibility of civil and political rights and economic social rights at the Vienna World Conference on Human Rights in 1993.[1] Around the same time, the development community began to see the advantages in terms of political economy in invoking the language of human rights to enhance its cause. And a diverse range of groups began to actively exploit what they recognized as the complementarity of the human rights and development agendas.[2] The right to health thus became something of value to a constituency well beyond a limited group of human rights advocates. In the late 1990s, the Committee on Economic Social and Cultural Rights (ESC Committee) adopted its General Comment on the right to health[3] and the Commission on Human Rights appointed the first Special Rapporteur on the right to

[1] *Vienna Declaration and Programme of Action*, UN Doc A/CONF.157/23 (12 July 1993) para 8.

[2] Mac Darrow and A Tomas, 'Power, Capture and Conflict: A Call for Human Rights Accountability in Development Cooperation' (2005) 27 Hum Rts Q 471, 472; Philip Alston, 'Ships Passing in the Night: The Current State of the Human Rights and Development Debate Seen through the Lens of the Millennium Development Goals' (2005) 27 Hum Rts Q 755, 798–807; Peter Uvin, 'From the Right to Development to the Rights-Based Approach: How "Human Rights" Entered Development' (2007) 17 Development in Practice 597; *Report of the Special Rapporteur on the Right to Health to the Human Rights Council 2011*, UN Doc A/HRC/17/25 (12 April 2011) paras 7–13.

[3] ESC Committee, *General Comment No 14: The Right to the Highest Attainable Standard of Health*, UN Doc E/C/12/2000/4 (11 August 2000).

health in 2002 with a mandate to develop a collaborative understanding of the measures required to promote and protect the right to health.[4] Parallel to these developments, academics and practitioners started to explore the linkages between health and human rights;[5] dedicated journals started to engage with the idea and consequences of perceiving health as a human right;[6] civil society started to integrate the right to health into their advocacy;[7] universities began to teach courses on health and human rights;[8] and domestic courts in jurisdictions such as South Africa, India, and Columbia delivered decisions guaranteeing access to medicines and emergency medical treatment.[9] Internationally, the right to health began to infuse the work of bodies such as the World Health Organization (WHO),[10] the United Nations Children's Fund (UNICEF),[11] and the Millennium Development Project.[12] Thus, after remaining largely dormant for several decades after its initial recognition in the WHO Constitution in 1946 and the Universal Declaration of Human Rights (UDHR) in 1948, the right to health has begun to assert a role for itself in debates over health policy, service delivery, and development policy generally.

This is not to say that the right has conquered all of the obstacles that have for so long stood in its way. However, in a recent analysis John Harrington and Maria Stuttaford suggest that:

the human right to health has moved to the centre of political debate and social policy across the globe. Civil society organizations have put this right at the heart of campaigns for health justice at national and global levels. It features prominently in the output of the United

[4] Commission on Human Rights, *The Right of Everyone to the Highest Attainable Standard of Health*, Res 2002/31, UN Doc E/CN.4/RES/2002/31 (22 April 2002) para 5.

[5] See, eg, Jonathan Mann and others (eds), *Health and Human Rights: A Reader* (Routledge, 1999); Sofia Gruskin and others (eds), *Perspectives on Health and Human Rights* (Routledge, 2005); Paul Farmer, *Pathologies of Power: Health, Human Rights and the New War on the Poor* (University of California Press, 2005) ch 9; Elizabeth Fee and Manon Parry, 'Jonathan Mann, HIV/AIDS and Human Rights' (2008) 19 J Pub Health Pol'y 54.

[6] See, eg, 'Health and Human Rights: An International Journal' <http://www.hhrjournal.org/index.php/hhr> accessed 14 June 2011; 'International Health and Human Rights' <http://www.biomedcentral.com/bmcinthealthhumrights> accessed 14 June 2011. *The Lancet*, one of the world's leading medical journals, has for some years included papers on health and human rights.

[7] See generally *Report of the Special Rapporteur on the Right to Health to the Human Rights Council 2007*, UN Doc A/HRC/4/28 (17 January 2007) paras 12–17.

[8] See Daniel Tarantola and Sofia Cruskin, 'Health and Human Rights Education in Academic Settings' (2006) Health & Hum Rts 297.

[9] See, eg, *Minister of Health v Treatment Action Campaign (No 2)* [2002] 5 SA 721 (CC, Sth Afr); *Paschim Banga Khet Mazdoor Samity v State of West Bengal* (1996) 4 SCC 37 (SC, India); Judgment No SU-225/98, 10.3.1998 (CC, Columbia).

[10] See Benjamin Meier, 'Global Health Governance and the Contentious Politics of Human Rights: Mainstreaming the Right to Health for Public Health Advancement' (2010) 46 Stan J Intl L 1, 35–42. See also WHO, 'Health and Human Rights' <http://www.who.int/hhr/en/> accessed 7 June 2011.

[11] Marta Santos-Pais, *A Human Rights Conceptual Framework for UNICEF* (Innocenti Essays No 9, UNICEF and ICDC 1999).

[12] Lynn P Freedman and others, UN Millennium Project Task Force on Child Health and Maternal Health, *Who's Got the Power? Transforming Health Systems for Women and Children* (Earthscan, 2005) 31.

Nations (UN) and regional human rights bodies, as well as national courts and legislatures; national constitutions increasingly include explicit recognition of the right to health. Long neglected in the legal academy, many scholars now labour to develop its normative content, to contextualize its application and to evaluate it from the point of view of moral philosophy and theories of justice.[13]

As a result of what they describe as 'this remarkable transformation',[14] they conclude that we have 'moved beyond the period of defensiveness when most discussion of the right to health was detained by the existential question of whether it could ever exist in the first place'.[15]

The claims of Harrington and Stuttaford suggest that the right to health is playing a central and prominent role in shaping the development of health policy and delivery of health services around the globe; that an understanding as to the meaning and implementation of the right to health has been developed and accepted. But are their claims as to the impact of the right to health and its meaning justified? Is it true that we have moved beyond a period of defensiveness and have arrived at the point where we can collectively explore the potential of this right to deliver just and equitable health outcomes? Have we developed an adequate foundation for its moral and philosophical basis? Have we developed an account of its normative content that moves beyond an empty aspirational slogan? And have we developed a sufficient understanding of the measures required to translate this account into practice—what is increasingly referred to as a rights-based approach to health?[16]

But for all of the dramatic progress that has been achieved, it is not at all clear that the right to health has in fact 'moved to the *centre* of political debate and social policy across the globe'. The empirical evidence that is reviewed in this book would suggest that the status and relevance of the right to health is much less secure and far more marginalized than such a claim would indicate. In anecdotal terms, this is illustrated by the major health care debate that took place in the United States in 2009–10. While candidate Barack Obama endorsed the concept of a right to health care,[17] President Obama opted instead to locate the underpinnings of his health reform

[13] John Harrington and Maria Stuttaford, 'Introduction' in John Harrington and Maria Stuttaford (eds), *Global Health and Human Rights* (Routledge, 2010) 1.

[14] ibid 2. [15] ibid 5.

[16] See, eg, Alicia Yamin, 'Will We Take Suffering Seriously? Reflections on What Applying a Human Rights Framework to Health Means and Why We Should Care' (2008) 10 Health & Hum Rts 45; Alicia Yamin, 'Suffering and Powerlessness: The Significance of Participation in Rights-Based Approaches to Health' (2009) 11 Health & Hum Rts 5; John Tobin, 'Beyond the Supermarket Shelf: Using a Rights Based Approach to Address Children's Health Needs' (2006) 14 Intl J Child Rts 275; *Report of the Special Rapporteur on the Right to Health to the Human Rights Council 2011* (n 2).

[17] See 'The Second Presidential Debate', *New York Times* (New York, 7 October 2008) <http://elections.nytimes.com/2008/president/debates/transcripts/second-presidential-debate.html> accessed 14 June 2011 ('Brokaw: "Quick discussion. Is health care in America a privilege, a right, or a responsibility?" . . . Obama: "Well, I think it should be a right for every American. In a country as wealthy as ours, for us to have people who are going bankrupt because they can't pay their medical bills—for my mother to die of cancer at the age of 53 and have to spend the last months of her life in the hospital room arguing with insurance companies because they're saying that this may be a pre-existing condition and they don't have to pay her treatment, there's something fundamentally wrong about that."')

agenda in the principles of cost effectiveness and economic sustainability.[18] In Australia, although policy makers have accepted the linkage between health and human rights, the idea of the right to health was conspicuously absent in shaping the adoption of health care reforms in 2011.[19] Similarly, in the United Kingdom the right to health was not included in the list of 10 principles that underlie its global health strategy.[20] Moreover, as the privatization of health care assumes a greater role in the provision of health care within states, there is little evidence to suggest that the impact of this development on the right to health has been taken into account. At the international level, institutions such as the WHO still struggle to make the transition from a biomedical model of health to a rights-based approach and the 'human rights agenda has remained marginal, contested and severely under-resourced'.[21] And where health concerns intersect with international trade and intellectual property rights, the right to health has remained relatively marginalized.[22] Indeed, Upendra Baxi has gone so far as to suggest that the disregard by the global pharmaceutical industry of the health needs of the South 'mocks' the very idea of a human right to health.[23]

On the domestic front, effective constitutional protection of the right to health remains the exception rather than the norm. And enthusiasm for the right to health is far from universal within the academic literature or among professional bodies. Recent expositions of the relationship between justice and health care tend to assign the right to health a relatively minor or non-existent role.[24] Philosophers such as James Griffin are scornful of what they perceive as the weak philosophical foundations of the right to health in international law;[25] while economists such as William Easterly believe a right to health will skew resources to benefit politically

[18] See, eg, 'Text: Obama's Speech on Health Care Reform', *New York Times* (New York, 15 June 2009) <http://www.nytimes.com/2009/06/15/health/policy/15obama.text.html?_r=1> accessed 13 July 2010, cf Edward Kennedy, 'Health Care as a Basic Human Right: Moving from Lip Service to Reality' (2009) 22 Harv Hum Rts J 165.

[19] See Australian Labor Party, 'Health Reform—A Healthy System for the 21st Century' <http://www.alp.org.au/agenda/health-reform> accessed 10 June 2011. The right to health is also absent from other Government strategies and inquiries in relation to health issues. See, eg, Department of Health and Ageing, *Primary Health Care Reform in Australia: Report to Support Australia's First National Primary Health Care Strategy* (Australian Government, 2009); House of Representatives Standing Committee on Health and Ageing, *Weighing It Up: Obesity in Australia* (Parliament of Australia, 2009).

[20] UK Department of Health, *Health is Global: A UK Government Strategy 2008–2013* (UK Government, 2008) 8.

[21] Paul Hunt, 'The Health and Human Rights Movement: Progress and Obstacles' (2008) 15 JLM 714, 723.

[22] See Chapter 9, Part III.

[23] Upendra Baxi, 'The Place of the Human Right to Health and Contemporary Approaches to Global Justice' in Harrington and Stuttaford (n 13) 12, 19.

[24] See, eg, Norman Daniels, *Just Health: Meeting Health Needs Fairly* (CUP, 2008) 15; Yvonne Denier, *Efficiency, Justice and Care: Philosophical Reflections on Scarcity in Health Care* (Springer, 2007). cf Jennifer Ruger, *Health and Social Justice* (OUP, 2010) 118; Amartya Sen, 'Why and How is Health a Human Right?' (2008) 372 The Lancet 2010.

[25] James Griffin, *On Human Rights* (OUP, 2008) 208.

effective advocates at the expense of the most needy.[26] Even in the medical literature, and especially in those journals where the central role of the right to health would most likely be affirmed such as the American Journal of Public Health and the European Journal of Public Health, articles embracing the right to health remain rare. Indeed, within the medical profession and among public health professionals generally, the right to health remains a relatively novel concept. For the most part, preference continues to be given instead to the notion of equity as the foundation or cornerstone of a just health care system.[27]

This reluctance to embrace the right to health by non-lawyers is linked, in part at least, to its legal origins and creates an urgent need to think about ways of developing an interdisciplinary understanding of the right. But even within legal circles there remain serious reservations as to the legitimacy of the right to health that stem from concerns regarding its capacity to hold a determinate meaning and its justiciability before courts. South Africa, Colombia, and Brazil may have included a right to health in their constitutions, but many other jurisdictions, including Australia and the United Kingdom, have steadfastly refused to do so.[28] And despite attempts over the last decade or so to articulate a vision of the right to health and a deeper understanding of its core principles, concerns as to its meaning and implementation in practice remain widespread. For example, the notion that the right to health has some sort of minimum core has been criticized,[29] and its overall normative content remains heavily contested. Insistence on the centrality of the principle of non-discrimination and on the indivisibility of the right to health with other human rights have been a source of deep frustration for many policy makers who must deal with the reality of scarce resources.[30] This inevitably demands that tough choices be made to give priority to some rights over others and to the claims of some rights-holders over others. Such conflicts and dilemmas arise in a great many contexts such as between young and old, between those living in urban areas and those in remote rural areas, and those with chronic diseases that are costly to treat and those whose interests are best served by an emphasis on basic primary care. The question is always whether the concept of a right to health is helpful in resolving such dilemmas.

[26] William Easterly, 'Human Rights are the Wrong Basis for Healthcare', *Financial Times* (London, 12 October 2009) <http://www.ft.com/cms/s/0/89bbbda2-b763-11de-9812-00144feab49a.html#axzz1PDNbqlAS> accessed 14 June 2011.

[27] Hunt (n 21) 714 (notes that 'many health professionals have never heard of the right to health').

[28] See, eg, UK Joint Committee on Human Rights, *Twenty First Report* (UK Parliament 2004) ch 4, paras 52–5 ('The Status of Economic Social and Cultural Rights') <http://www.publications.parliament.uk/pa/jt200304/jtselect/jtrights/183/18307.htm> accessed 10 June 2011; *National Human Rights Consultation Report* (Commonwealth of Australia 2010) 355–6.

[29] See, eg, Katharine Young, 'The Minimum Core of Economic and Social Rights: A Concept in Search of Content' (2008) 33 Yale J Intl L 113.

[30] Lauchlan Munro, '"The Human Rights-Based Approach to Programming": A Contradiction in Terms?' in Sam Hickey and Dianas Mitlin (eds), *Rights-Based Approaches to Development: Exploring the Potential and Pitfalls* (Kumarian Press, 2009) 187, 197–201. Indeed, Richard Horton, as Editor of the Lancet in 2004, suggested that the obsession with the indivisibility of rights was undermining child survival: Richard Horton, 'UNICEF Leadership 2005–2015: A Call for Strategic Leadership' (2004) 364 The Lancet 2071.

Moreover, the concept of participation—invoked as a mantra with respect to all rights including the right to health—has been criticized for bypassing the hard problems associated with those whose situation or status effectively preclude them from any meaningful participation.[31]

A picture therefore emerges of the right to health that is far more contested and much less central to political and social debates concerning health care than its most enthusiastic advocates would suggest. But this is a far cry from concluding that the right to health is irrelevant. On the contrary there is no doubting that it is increasingly an unavoidable part of public health discourse. The central challenge now is to move the right from the periphery to the centre of such debates, a challenge that will require far more sophisticated and hard-headed analysis on the part of lawyers, health professionals, and public policy makers. This book aims to contribute to meeting that challenge.

I Clarifying expectations

In responding to this challenge, no attempt is made to traverse the relationship between the right to health and the broad range of specific health sector issues confronting contemporary societies. Such an approach would simply descend into an eclectic and subjective collection of issues that would inevitably be treated superficially and add little to the existing literature. Instead, the approach adopted in this book is to anchor the analysis to a discussion of the core principles that inform the status, content, and implementation of the right to health in the hope that the reader will be able to apply these principles to specific health sector issues. This is not to say that there will be no discussion of specific issues—the centrality and prominence of issues such as the privatization of health care, the role of non-state actors, access to medicines, and reproductive health demand inclusion in any book on the right to health in international law. However, rather than devote separate chapters to these issues, their treatment will be designed to illustrate the application of the core principles that are the central focus of this book.

Moreover, no attempt is made to comprehensively examine the meaning of the right to health as it appears in international, regional, *and* domestic contexts. Instead, the focus of this book is on the right to health in international law and primarily the formulation adopted in the International Covenant on Economic, Social and Cultural Rights (ICESCR)[32] and the Convention on the Rights of the

[31] Baxi (n 23) 18.

[32] International Covenant on Economic Social and Cultural Rights (ICESCR) (New York, 19 December 1966, entered into force 3 January 1976, 993 UNTS 3) art 12:

1 The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2 The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

Child (CRC)[33] because these two instruments offer the most comprehensive expression of the right in international law.[34] Attention will be drawn to other international, regional, and domestic instruments that address the right to health but only for the purpose of highlighting the way in which such instruments expand, inform, or deviate from the nature of this right in international law.[35] As a consequence this book does not provide a detailed examination of the regional and domestic case law

(b) The improvement of all aspects of environmental and industrial hygiene;
(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

[33] Convention on the Rights of the Child (CRC) (New York, 20 November 1989, entered into force 2 September 1990, 1577 UNTS 3) art 24:

1 States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.
2 States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
(a) To diminish infant and child mortality;
(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
(d) To ensure appropriate pre-natal and post-natal health care for mothers;
(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;
(f) To develop preventive health care, guidance for parents and family planning education and services.
3 States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.
4 States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

[34] As at 12 August 2011, 160 states were party to the ICESCR and 193 states were party to the CRC. No state has entered a general reservation to art 12 of the ICESCR upon ratification or accession. Three states—Argentina, the Holy See, and Poland—have entered reservations upon ratification or accession to the CRC in relation to those aspects of art 24 which concern family planning. However, no state has entered a broad reservation to the obligation to recognize the right of a child to the highest attainable standard of health.

[35] See Appendix 1 for a listing of the right to health as it appears in other international and regional treaties. For a more detailed listing of international instruments relevant to the right to health see: *Report of the Special Rapporteur on the Right to Health to the Commission on Human Rights*, UN Doc E/CN.4/2003/58 (13 February 2003) annex 1. For a comprehensive examination of the history and development of the international normative structure see Brigit Toebes, *The Right to Health as a Human Right in International Law* (Hart Publishing, 1999) 27–85. For a timeline of the significant international developments relevant to a child's right to health see WHO, *The World Health Report 2005: Make Every Mother and Child Count* (WHO, 2005) 5.

on the right to health as appears for example in the African Charter on Human and People's Rights or the South African and Colombian constitution. Such case law is relevant to the extent that it demonstrates the justiciability of a right to health. But a detailed examination of the right to health in regional or domestic legal systems is beyond the scope of this book.

II Constructing a meaning for the right to health

It has been said that 'one would be hard pressed to find a more controversial or nebulous human right than the "the right to health"'[36] which 'is characterized by conceptual confusion as well as a lack of effective implementation'.[37] This characterization presents a significant problem for a project that seeks to deploy the right to health as a strategy to influence health outcomes and provide guidance for states seeking to implement their obligations under international law.[38] Although significant work has been done in recent years to 'unpack'[39] various aspects of the right to health by bodies such as the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, the Committee on Economic Social and Cultural Rights (ESC Committee), the Committee on the Rights of the Child (CRC Committee) and academic commentators, the contours of this right are far from fully mapped.

A The history of the right to health

Rather than leap straight into the task of developing the normative content of the right to health, the approach taken here is to begin with an account of the historical, philosophical, and theoretical journey of this concept. This is because an examination of the history of the right to health has the potential to reveal insights into the intended meaning of this right and clarify debates as to the source of its origins. The idea of a right to the highest attainable standard of health is, after all, a bold exhortation, and its inclusion in international instruments was not the result of some divine act of intervention. It carried expectations for its authors but what were they and why were states, sovereign bodies accountable to no other entity at the time, prepared to accept such an obligation?

[36] Jennifer Ruger, 'Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements' (2006) 18 Yale JL & Hum Rts 273.

[37] Toebes (n 35) 259–60.

[38] Lawrence Gostin, 'Global Health Law Governance' (2008) 22 Emory Intl L Rev 35, 36 (identifies lack of definition as a serious structural problem within international law); *Report of the Special Rapporteur on the Right to Health to the Human Rights Council 2007* (n 7) para 8 (notes that the gap in understanding of the right to health placed a significant constraint on all those working in the field of health and human rights especially during the 1990s).

[39] *Report of the Special Rapporteur on the Right to Health to the General Assembly 2007*, UN Doc A/62/214 (8 August 2007) para 70.

The examination of the history of the right to health undertaken in Chapter 1 reveals that this right is not, as is often assumed, the product of Communist ideology. On the contrary the lineage of this right is interwoven with the genes of a diverse range of actors—the legacy of the Enlightenment, the failings of the Industrial revolution, the development of a distinct Latin American philosophy that was heavily steeped in Catholic values about justice, the impact of the Great Depression, the emergence of the modern welfare state, and the personality of individuals such as Franklin D Roosevelt. It is also deeply interconnected with the history of public health, which reveals an ancient acceptance of the need for states to take measures to protect the health of their people. Significantly, this is the basic premise that underlies the right to health. Historically, the motivations for public health measures tended to shift in a pendulum-like way from instrumentalism to humanitarianism—an excessive swing towards instrumentalism always proving counterproductive to both the interests of the state and individual because of increased poverty, disease, and sickness thus necessitating a counter swing towards humanitarianism. However, the horrors of World War II provided both the impetus and window of opportunity in which states agreed upon a conception of the right to health that recognized the interdependence of humanitarian and instrumental motivations. Thus, far from being an abstract ideology or utopian dream, the history of the right to health reveals this idea to be endowed with deeply pragmatic origins.

B The conceptual foundations of the right to health

An examination of the conceptual foundations of the right to health, which is the focus of Chapter 2, is warranted for both strategic and substantive reasons. For many philosophers, the right to health simply cannot be justified. It is said to lack a convincing theoretical account of its conceptual foundations[40] and is a 'vacuous concept' that should be demoted from the list of human rights recognized under international law.[41] Such a position not only has a destabilizing effect on the legitimacy of the right to health, but if correct, it makes any attempt to interpret this right look like a futile exercise. As a consequence, there is a need to see if a philosophical defence of the right to health can be offered. If such a defence can be mounted, it has the potential to both ward off the skeptics and provide a stronger theoretical foundation upon which to erect the normative content of the right.

The conclusion to be drawn is that such a justification does exist. This defence is based on what is described as a social interest theory of rights. The fundamental tenet of this theory is that human rights are not essential or inherent but socially constructed and it is 'interests' that ground human rights. However, it rejects the idea that the interests which ground a right must be determined by reference to a comprehensive theory as to when a particular interest will constitute the foundation for a legitimate human right. It also rejects the suggestion that the international instruments that protect the right to health offer no agreement on the conceptual

[40] Daniels (n 24) 15. [41] Griffin (n 25) 208.

foundations of human rights such as a right to health.[42] Instead, it will be argued that, although not completely theorized, there is an overlapping consensus as to the conceptual foundations of the right to health in international law, which is derived from the social process that led to the recognition of a person's interest in achieving the highest attainable standard of health as the basis for a human right. Hence the idea of a 'social interest' theory of rights as opposed to other explanations, such as an 'urgent'[43] or 'basic' interest theory.[44]

Chapter 2 also interrogates those arguments commonly used to challenge the legitimacy of the right to health, which are described as the libertarian objection; the status objection; the formulation objection; the relativist challenge; and the resource allocation dilemma. This discussion reveals that much of the conceptual opposition to the right to health is based on a theory of rights that is inapposite to the theory of human rights adopted in international law. Moreover, most of the opposition based on implementation of the right to health is informed by assumptions as to the scope of the right to health and the nature of a state's obligations, which pay no regard to the actual obligations of a state as expressed within the relevant human rights treaties. A careful examination of the text of these treaties, which is the focus of the discussions in Chapters 4 to 9, reveals that such objections are without foundation.

C The need for a persuasive methodology

All too often the process of defining the content of a human right, such as the right to health, is unaccompanied by any explanation or at best a scant explanation, as to the methodology used to generate the interpretation offered.This gives rise to allegations of 'sloppy' humanitarian argument[45] and a tendency towards 'result driven jurisprudence', which reflects the personal preferences of the interpreter.[46] In response to these concerns, Chapter 3 is dedicated to outlining the methodology to be adopted with respect to the meaning of the right to health in international law. The fundamental premise of this methodology is that the act of interpretation is not simply the process of attributing *a* meaning to the right to health but ultimately an act of persuasion—an attempt to persuade the relevant interpretative community that a particular interpretation of the right to health is the most appropriate meaning to adopt. Importantly, this community extends beyond states, their agents, and international lawyers towards a more communitarian model in which the interests *and* insights of a much wider range of stakeholders who have an interest in the right to health, must be taken into account in the interpretative exercise—a process described as constructive engagement. Ultimately it is argued that a persuasive

[42] Griffin (n 25) 16.

[43] Charles Beitz, *The Idea of Human Rights* (OUP, 2009) 109–10.

[44] Allen Buchanan and Kristen Hessler, 'Specifying the Content of the Human Right to Health Care' in Allen Buchanan (ed), *Justice and Health Care: Selected Essays* (OUP, 2009) 213.

[45] David Kennedy, 'The International Human Rights Movement: Part of the Problem?' (2001) 14 Harv Hum Rts J 101, 120.

[46] Jeremy Waldron, 'Judges as Moral Reasoners' (2009) 7 Int J Constitutional Law 2, 6.

interpretation of a right such as health will be enhanced if it satisfies four criteria—it must be principled, practical, coherent, and context sensitive.

D The meaning of health

Chapter 4 commences the task of applying the methodology outlined in Chapter 3 to develop a meaning of the right to health in international law. The focus in this chapter is on the meaning and scope of the interest in which this right is grounded namely, the highest attainable standard of physical and mental health. It advances four arguments. First, far from guaranteeing a right to be healthy, as suggested by some commentators, the phrase 'highest attainable standard' recognizes that the level of health enjoyed by an individual will be dependent on factors peculiar to an individual and the resources available to a state. Second, the actual meaning of health, which has been largely overlooked by the human rights treaty supervisory bodies, should extend to a biopsychosocial model, which recognizes the potential for social factors, and not merely a pathological condition, to limit the functioning of an individual within society. This approach provides better guidance for states in identifying the measures necessary to secure the right to health relative to the traditional biomedical definition. Third, a persuasive case can be made to extend the scope of the right to health to freedoms the implications of which will be examined in the context of sexual autonomy for adolescents, consent to medical treatment, and the practice of non-consensual sterilization of women and girls with intellectual disabilities. Finally, the four qualitative elements of the right to health—that health care and related services be available, accessible, acceptable, and of appropriate quality—support an understanding of this right that is practical, or to borrow the words of Beitz and Griffin, 'action guiding'[47] and 'socially manageable'[48] for states.

E The obligation of states to recognize the right to health

An adequate normative account of a human right requires that it have a well-specified counterpart obligation. Chapters 5 to 9 offer a response to this challenge. Chapter 5 examines the meaning of the requirement under international law that states must take steps by all appropriate means to secure the right to health. It draws significantly on the work of the treaty supervisory bodies, principally the ESC Committee and the CRC Committee, to inform the scope of this obligation. Although this work is shown to be unreasonably conflated at times, a persuasive case can still be made to support the calls of the treaty supervisory bodies that states must adopt the following measures to secure the effective enjoyment of the right to health—the development of national health plans; the creation of effective accountability mechanisms; the collection of appropriate data and development of relevant indicators and benchmarks; the facilitation of effective participatory strategies; the

[47] Beitz (n 43) 163. [48] Griffin (n 25) 37–8.

encouragement of multisectoral and interdisciplinary initiatives; and the development of targeted health policies for especially vulnerable groups.

Chapter 6 examines the meaning of the obligation to secure the right to health progressively subject to available resources. It argues that despite the apparently amorphous nature of this obligation, it remains possible to articulate a persuasive account of how states can implement this obligation in a way that is principled, practical, coherent, and context sensitive. A process will also be outlined by which to guide states in the resolution of the macro/micro resource allocation dilemma, outlined in Chapter 2. It will be shown that international law accommodates the reality of the need for states to prioritize the allocation of scarce resources provided that the state is able to demonstrate that the process for allocating these resources can be shown to be reasonable. This standard will be satisfied where the decision-making process is shown to be principled, evidence based, consultative, transparent, and evaluative. The chapter concludes with an analysis of the controversial concept of minimum core obligations. It will be argued that the ESC Committee has inflated this concept as it applies to the right to health in a way that fails to satisfy any of the requirements outlined in the interpretative methodology to be used in this analysis. But rather than abandon this concept, it will be argued that a principled and practical defence can be advanced to justify its use as a tool to assist in understanding the nature of a state's obligation to secure the right to health within the context of limited resources.

Chapter 7 examines the nature of the obligations imposed on states with respect to the specific measures listed in article 12 of the ICESCR and article 24 of the CRC which range from an obligation to diminish child mortality to an obligation to develop preventive health care including family planning education and services. The central theme to emerge from this analysis is that considerable deference must be given to states' margin of appreciation to allow for a context sensitive implementation of the specific measures required to secure the right to health in international law. However, this margin remains subject to the overriding caveat that whatever measures are adopted by states they must be undertaken in a manner that is directed towards securing the effective implementation of the right to health and pursue coherence with the other obligations imposed under the ICESCR, the CRC, and the broader system of international law. Moreover, the requirement that the measures be 'appropriate' demands that they must also be effective—as assessment that requires extensive engagement with research from a broad range of non-legal disciplines such as public health and pediatrics.

It is now widely acknowledged that a person's health is not merely compromised by gaps in medical knowledge, a lack of health services, or inadequacies in the social determinants of health. Many traditional practices are also maintained despite their prejudicial impact on the health of individuals. As a consequence, the right to health in international law imposes an obligation to abolish such practices. The nature and scope of this obligation is the focus of Chapter 8 and the conclusions to be drawn are as follows. First, the obligation to abolish harmful traditional practices is a progressive one which requires states to take a combination of whatever measures are necessary—legislative, administrative, social, and education—to ensure the effective

eradication of such practices. Second, an assessment as to the prejudice of a particular practice to the health of a child cannot be reduced to a simple biomedical assessment and the broader psycho-social impacts and significance of a practice must be taken into account. Third, an examination of the treatment of corporal punishment and male circumcision by the CRC Committee provides evidence of both a cultural and gender bias in the identification of practices deemed harmful to the health of a child. Fourth, the practice of female genital cutting will be used to demonstrate that rather than adopt a simple legislative regime based on zero tolerance, a multifaceted approach, which is generated through dialogue with the communities that tolerate harmful practices, must be adopted if the effective elimination of harmful practices is to be achieved. Finally, although the right to health under the ICESCR does not include a specific obligation to abolish harmful traditional practices, it is reasonable to imply such an obligation in the general obligation of states to take measures to protect the health of individuals from the practices of non-state actors.

Chapter 9 examines the highly contested and elusive nature of the international obligation to cooperate for the purpose of securing the realization of the right to health in international law. The overarching conclusion to be drawn is that although the 'parameters of international assistance and cooperation are not yet fully drawn',[49] it remains possible to articulate 'a convincing account' as to the scope of the obligation 'in order to articulate its concrete implications for states with respect to the areas and means by which co-operation should take place.[50] Central to this account is the requirement that states must take reasonable measures subject to available resources to *respect, protect*, and *fulfil* the right to health of individuals in other states. This typology of obligations is illustrated by way of a case study, namely access to medicines within the context of the international system for the protection of intellectual property under the Trade-Related Aspects of Intellectual Property Rights (TRIPS) regime, to assess the legitimacy of a state's involvement in this regime. It concludes that, on balance, involvement in TRIPS does not necessarily violate the *respect* and *protect* elements of a state's international obligation to secure the right to health. But this regime is not an effective mechanism by which to facilitate access to medicines in developing states and the international obligation to *fulfil* the right to health requires that states must make bona fide efforts to develop a complementary system that is more likely to achieve this end.

[49] *Report of the Special Rapporteur on the Right to the Highest Attainable Standard of Health to the General Assembly 2005*, UN Doc A/60/348 (12 September 2005) para 60.

[50] Allen Buchanan and David Golove, 'The Philosophy of International Law' in Jules Coleman and Scott Shapiro (eds), *The Oxford Handbook of Jurisprudence and Philosophy of Law* (OUP, 2002) 868, 906.