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Health as a Human Right

Erasmus University Rotterdam

2.1 INTRODUCTION

At all times, being a member of a group, such as a family, class, religion, community or state involves individual rights and responsibilities. The tradition of "do unto others as you would like them to do unto you" has been a common tradition in most societies. Universally, all ancient societies have had ethical concepts and a system of duties about human beings. Many of them even correspond to obligations, values and conceptions of justice and political legitimacy related to modern human rights.[1] The Hindu Vedas, the Babylonian Code of Hammurabi, the Bible, the Quran, the Analects of Confucius and the Cyrus Cylinder are six of the oldest written sources that address governments' and people's duties and responsibilities. However, they generally lacked a concept of "human rights"; no word for "right" can be found in any ancient or medieval language before 1400 B.C.[2] Although religious and secular traditions might have shared basic views of a common good, they did not consider every individual equal.[3]

2.2 HUMAN RIGHTS

At national levels, the promotinn of individual rights started long before the Second World War (1939-1945). Examples are the English Magna Carta in 1215 and the Act of Rights and Liberties of the Subject and Settling the Succession of the Crown and the Scottish Claim of Right in 1689, which prohibited some unjust actions of governments. In addition, the Inca and Aztec Codes of Conduct and Justice and the Iroquois Constitution (Native American sources) existed before the 18th century.[4] The American and French Revolutions were important movements focused on creating national policies based on human rights in the 18th century.[5] The United States Declaration of Independence and Constitution (1776, 1787) and the French Declaration of the Rights of Man and the Citizen (1787) established certain legal

1 Donnelly, J. *Universal Human Rights in the Theory and Practice* (3rdedn, Cornell University, USA 2013) 71
2 Freeman, M. *Human Rights: an Interdisciplinary Approach* (2ndedn, Polity Press, USA and UK 2001) 16
3 Ishay, M. 'What are human rights? Six historical controversies' [2004] Journal of Human Rights3(3) 359-371
4 Shiman, D. *Teaching Human Rights* (Center for Teaching International Relations Publications, University of Denver, 1993) 6-7
5 Forsy, P. D. *Human Rights in International Relations* (2ndedn, Cambridge University Press, 2006) 3

rights.[6] Furthermore, the Virginia Declaration of Rights (1776) encoded a number of fundamental civil rights and freedoms into law. In the 19th century, abolishing slavery was a considerable step towards the equality of human beings in the United States.[7] During this century mistreatment of Jews in Russia and Christians in Turkey was noticeable. Establishment of the League of Nations at the end of the First World War (1914-1918), as the first international body that made states accountable for the mistreatment of minorities and indigenous populations in the mandated territories, was a turning point in the protection of people's rights.[8] Treaties such as the Geneva Conventions of 1864, 1907 and 1929 for the protection of people, including the wounded, civilians and prisoners of war during armed conflicts were drafted to safeguard individual rights.

Among economic, social and cultural rights, a set of rights that received special attention was work-related rights. They originated from the Industrialization era in the 19th century, when poverty and life-threatening work situations (which were accepted as realities of life and a matter of destiny) led specific groups of societies to raise issues with landowners and local lords. Workers' complaints and the high rate of work-related injuries were incentives for countries to enact rules for factories about worker safety, the provision of health services and compensation to address work injury, disability, old age, and unemployment. In the 20th century, the strong position of workers in the market resulted in access to social services, insurance and healthcare. Considerable efforts were made to promote labour rights through an international organization. With the establishment of the International Labour Organization (ILO) in 1919, the content of labour rights was developed.[9] Some protected rights in the Constitution of the ILO are rights to occupational safety, compensation in case of work injury, creating and joining unions and striking. This organization was the most successful human rights international organization in terms of standard setting and enforcement techniques established before the foundation of the United Nations. However, these rights were not the rights of all people, particularly vulnerable social groups, who often were not able to satisfy their basic needs; instead, they were only for workers who had permanent jobs and consequently were better able to access social benefits.[10]

6 Renteln, D. A. *International Human Rights: Universalism Versus Relativism* (Quid pro books, New Orleans 2013)17

7 Eide, A. 'Economic, Social and Cultural Rights as Human Rights', in Eide, A. Krause C. Rosas, A. (eds) *Economic, Social and Cultural Rights; a text book* (Martinus Nijhoff Publishers, The Netherlands, 1995) 27

8 Renteln, D. A. Supra note 6 at 17-19

9 Haxhiraj, A. 'Judicial Enforcement of Economic, Social and Cultural Right' [2013] Academicus International Scientific Journal MMXIII (8) 221-230

10 Renteln, D. A. Supra note 6 at 18-19

The First World War (1914–1918) and the Second World War (1939–1945) were major transformative events in the 20th century. Considerable movement for human rights in the 20th century originated from the atrocities that occurred during these two world wars.[11] Until 1945, before the establishment of the UN, human rights were mainly national issues. In the 20th century, approximately 35 million people died in armed conflicts, and perhaps 150-170 million people were killed by their own governments through preventable political murder or mass misery.[12] Many individuals were forced to abandon their property to move to new lands. Periods of hunger were common even in relatively prosperous Western Europe. Families were separated for long periods, particularly from their fathers. Horrendous crimes, such as the Holocaust and its abuses, were committed by fascist powers against humanity.[13] These issues encouraged countries to establish an international organization to promote world peace and prevent more wars. The United Nations (UN) was founded in 1945; Article one of the Charter of the UN defines the purpose of establishing this organization as "to maintain international peace and security,{…} to develop friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples,{…}to achieve international co-operation in solving international problems of an economic, social, cultural, or humanitarian character, and in promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction as to race, sex, language, or religion; and to be a centre for harmonizing the actions of nations in the attainment of these common ends."[14]

Very soon, it appeare that the Charter was not sufficient for the protection of people's rights. Moreover, no controlling system, standards or modes of enforcement were designed for the assessment of countries' compliance with the Charter. In addition, a country's signature on the Charter does not mean that the country will take steps to respect the Charter and to undertake related obligations.[15] Therefore, several eminent politicians and scholars in various international conferences drafted a different bill of people's rights. Some sub- committees and working groups were established to work on certain human rights issues, such as child labour, but the notion of "rights" has not been entered into treaties. The international community decided never to allow atrocities to occur again; world leaders devised a road map to guarantee the rights of every individual everywhere as a complement to the UN

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11 Forsy, P. D. supra note 5 at 3

12 Rummel, R. J. *Death by government* (Transaction Publishers, New Jersey 1997) 24

13 Kesternich, R. Siflinger, B. Smith, P. J. Winter, K. J. 'The Effects of World War II on Economic and Health Outcomes across Europe' [2014] The Review of Economics and Statistics 96 (1) 103-118.

14 Charter of the United Nations 1945, art 1, 55, 56

15 Renteln, D. A. Supra note 6 at 18

Charter. That road map was the Universal Declaration of Human Rights (1948).[16] The Declaration was inspired by Franklin Roosevelt's third Inaugural Address to the Congress in January 1941(He had been the president of the USA from 1933 to 1945). He wished for four types of freedoms for the world: freedom of speech, freedom of worship, freedom from want, and freedom from fear.[17] The Universal Declaration of Human Rights that defines the totality of rights was agreed without any negative votes of the UN members in 1948. According to this declaration, "recognition of inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world". It added that everyone is born free and equal in dignity and rights and is entitled to all human rights and freedoms (mentioned in the Declaration) without distinctions of any type.[18] Later, human rights discourse was broadened internationally.

In 1966, two separated human rights treaties were drafted: the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). Over a period of years, almost all countries ratified both covenants. In 1993, the High Commission for Human Rights was established by the United Nations General Assembly. In the 1990s, the International Criminal Court was established by the UN Security Council to investigate violations of the laws of war, genocide and crimes against humanity in certain countries.[19] Other developments in the area of human rights have been about more attention to the universality of these rights, and the adoption of domestic public policies for the realization of human rights and the rights of specific groups within populations.[20] The International Covenant on the Elimination of all Forms of Racial Discrimination (1965), the Convention on the Elimination of all Forms of Discrimination against Women (1979), the Convention on the Rights of the Child (1989), and the Convention on the Rights of People living with Disabilities (2006) are examples of this approach. Now, human rights are common public policies worldwide.

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16 United Nations, 'History of The Universal Declaration of Human Rights' (UN 2016) <http://www.un.org/en/sections/universal-declaration/history-document/index.html> accessed 2 May 2016

17 Morphet, S. Economic, Social and Cultural Rights; the Development of Governments' Views 1941-88 in Beddard R. Dilys M. Hill (eds) *Economic, Social and Cultural rights: Progress and Achievement* (Macmillan in association with the Mountbatten Center for International Studies, University of Southampton, 1992) 76

18 Universal Declaration of Human Rights 1948, preamble

19 Baruchello, G. Johnstone R. L. 'Rights and Value: Construing the International Covenant on Economic, Social and Cultural Rights as Civil Commons' [2011] Studies in Social justice5 (1) 91; Dilys M. Hill, 'Rights and their Realization' in Beddard R. Dilys M. Hill(eds) *Economic, Social and Cultural Rights: Progress and Achievement* (Macmillan in association with the Mountbatten Center for International Studies, University of Southampton, 1992) 2-8; Donnelly, J. Whelan, D. J. 'The West, Economic and Social Rights, and the Global Human Rights Regime: Setting the Record Straight' [2007] Human Rights Quarterly 29 (4) 908-949

20 Forsy, P. D. *Human Rights in International Relations* (2ndedn, Cambridge University Press, 2006) 4

At the regional level, a number of treaties such as the European Convention for the Protection of Human Rights and Fundamental Freedoms (1950), the European Social Charter (1961), the Revised European Social Charter (1996), the African Charter on Human and Peoples' Rights (1981), the African Charter on the Rights and Welfare of the Child (1990), the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003), the American Convention on Human Rights (1969), and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador) (1988) were drafted. The Cairo Declaration of Human Rights in Islam (1990), which was drafted by members of the Organization of the Islamic Conference (composed of 57 countries mainly located in Asia and Africa) is a treaty recognizing human rights according to Sharia. Unlike other continents, Asia, which is a large region composed of countries that are extremely diverse in culture and values and are frequently critical of Western models of political liberalism, has not established any inter-governmental Asia-wide organization for human rights.[21]

2.2.1 What is a Human Right?

The Oxford English Dictionary defines a "right" as a "legal, equitable, or moral entitlement or justifiable claim (on legal or moral grounds) to have or obtain something, or to act in a certain way; the advantage or profit deriving from this; a legal, equitable, or moral title or claim to the possession of property or authority, the enjoyment of privileges or immunities, etc.; (by extension) an entitlement considered to arise through natural justice (whether or not enshrined in legislation) and which is applicable to all members of a particular group."[22] Rights are inherent to the human person and essential for the life of a human being and are defined based on individuals' needs. These needs are endless and diverse for different people, who belong to different groups and communities worldwide. The background of the values of a certain society determines what is meant by the need and consequently which rights can be claimed.[23] Realizing all the rights of people is impossible, even theoretically; therefore, relative policies should be more selective, and priorities should be set. Aston believes that "if every possible human rights element is deemed to be essential or necessary, then nothing will be treated as though it is truly important. A list of requirements that is too demanding or ignores trade-offs and dilemmas is unlikely to be taken seriously by practitioners who are operating under major resource and time

21 Ibid at 148-149
22 Oxford English Dictionary online, "right" <http://www.oed.com/> accessed 12 May 2016
23 Dilys, M. Hill, supra note 19 at 4

constraints and are faced with competing priorities and the need to make difficult choices."[24] Thus, it is essential to give priority to the protection of certain rights.

According to the Committee on Economic, Social and Cultural Rights (CESCR), human rights are "fundamental, inalienable and universal entitlements belonging to individuals and, under certain circumstances, groups of individuals and communities."[25] Human rights in the Universal Declaration of Human Rights are norms rooted in moralities that demand implementation through national and international legal and political institutions.[26] These rights are politically and legally universal. They provide every individual with a legitimate claim upon society for defined benefits and freedoms.[27] Having a right means that when someone is denied the right (or is threatened with being denied that right), he is authorized to claim it. Human rights are equal rights; everyone has the same human rights as everyone else. Human rights are inalienable in the sense that no one stops being a human even when he behaves inappropriately. Rights are universal for all members of the human species throughout the world.[28] Nowadays, every state has ratified at least one core human rights treaty that reflects its consent to the legal obligations. This is a concrete expression of the universality of rights. Some fundamental human right norms are universally protected by customary international law across all boundaries.[29]

2.2.2 Evolutions of Human Rights

Evolutions of human rights can be seen in several dimensions. Initially, "the rights of a man" was the right of a white man. It took a long time for the United States, which was one of the frontiers of human rights to include black men in the concept of equal rights in the Constitution and to start the movement for non-discrimination on the grounds of colour, race and national origin. It took even longer to include women, and therefore to change from "rights of men" to "human rights". Later, the international community recognized that not only adults, but children as independent persons having rights. From another point of view, civil rights, the fundamental achievement of the 18th century were defined on the equality of all people before the law. Political rights, which emerged in the 19th century, are based on participation in

24 Alston, P. '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] Human Rights Quarterly 27 (3) 755-829

25 UN Committee on Economic, Social and Cultural Rights, *General Comment no. 17 ICESCR: The Right of Everyone to Benefit from the Protection of the Moral and Material Interests Resulting from Any Scientific, Literary or Artistic Production of Which He or She Is the Author* (2006) para1

26 Nickel, J. W. *Making Sense of Human Rights: Philosophical Reflections on the Universal Declaration of Human Rights* (University of California Press, 1987)107 & 174

27 Donnelly, J. 'The Relative Universality of Human Rights' [2017] Human Rights Quarterly 29 (2) 281-306

28 Donnelly, J. supra note 1 at 10

29 United Nations office of High Commissioner for Human Rights, 'What are Human Rights?' (UN 2016) <http://www.ohchr.org/en/issues/pages/whatarehumanrights.aspx> accessed 12 May 2016

the exercise of sovereign power. Social rights as the achievement of the 20th century aim to make it possible for all members of society to enjoy satisfactory conditions of life. More recent achievement of human rights movements is the special protection of individuals who are unable to take care of their needs such as detainees, prisoners and persons with mental illness. Humanitarian law supplements the ordinary human rights protection of persons affected by war or armed conflicts.[30]

In the literature of human rights, different "generations" of human rights can be observed. The first generation is negative human rights that require abstinence from interfering with personal freedoms. These rights include Civil and Political Rights (CPRs). CPRs that are enshrined in the International Covenant on Civil and Political Rights (ICCPR) include the right to life, the right to be free from torture, the rights to liberty and security of person, the right to freedom of movement, the right to a fair hearing, the right to privacy, the right to freedom of religion and expression, the right to peaceful assembly, the right to family life, the right of children to special protection, the right to participate in the conduct of public affairs, the right to equal treatment, and the special rights of members of ethnic, religious and linguistic minorities.[31]

The second generation of human rights refers to positive rights, or economic, social and cultural rights (ESCRs). The main emphasis of ESCRs is the claim on the state for the protection of vulnerable groups and for assistance.[32] They include a variety of rights, such as the right to work and to just and favourable conditions of work, the right to rest and leisure, the right to form and join trade unions and to strike, the right to social security, the right to protection of the family, mothers and children, the right to an adequate standard of living, including adequate food, clothing and housing, the right to the highest attainable standard of physical and mental health, the right to education, and the right to participate in cultural life and to enjoy the benefits of scientific progress.[33]

In recent years, a "third generation" of rights including the rights to development and peace has been introduced. The third generation of human rights is a highly complex mixture of rights that sometimes are called "Solidarity Rights", "Collective Rights" or "People's Rights".[34] Unlike the two other generations, these rights do

30 Eide, A. supra note 7 at 27

31 International Covenant on Civil and Political Rights1966, part III

32 Eide, A. Rosas, A. 'Economic, Social and Cultural Rights: A Universal Challenge' in Eide, A. Krause C. Rosas, A. (eds) *Economic, Social and Cultural Rights; a text book* (Martinus Nijhoff Publishers, The Netherlands, 1995) 11-17

33 International Covenant on Economic, Social and Cultural Rights 1966, part III

34 Freedman, R. 'Third Generation' Rights: is there room for Hybrid Constructs within International Human Rights Law?' [2013] Cambridge Journal of International and Comparative Law 4 (2) 935–959

not have solid legal foundations applicable in worldwide legal instruments.[35] Most human rights are interrelated and cover different aspects of the same basic concerns: freedom, integrity and equality of all human beings. Their realization depends upon the realization of those rights in other generations of rights. For example, the right to work, which provides an income, can ensure an adequate standard of living; unemployment and insufficient income deprives people of the enjoyment of an adequate standard of living.[36]

2.2.3 Human Rights Obligations

The obligations of states with respect to CPRs are to respect and ensure that all individuals within a country's jurisdiction enjoy the rights recognized in the ICCPR such as the rights to life and privacy, without distinction of any type. States are required to adopt necessary laws or other measures to give effect to the provisions of the Covenant at the domestic level. Each state should ensure that every person whose rights or freedoms are violated has a right to claim to a competent authority and is entitled to a remedy; governments are required to develop the possibilities of a judicial system that enforces such remedies when granted.[37] The ICESCR imposes three different types of obligations on states: to respect people's rights, to protect them from third party interference in their rights, and to fulfill people's rights. Failure to perform any one of these obligations constitutes a violation of such rights. Obligations in the treaty are set conditionally due to the various financial and economic possibilities of state parties. States are required to take steps to achieve the full realization of rights progressively because the full implementation of these rights is not possible in a short period of time for every state. The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights (1986) indicates that "the achievement of economic, social and cultural rights may be realized in a variety of political settings. There is no single road to their full realization. Successes and failures have been registered in both market and non-market economies and in both centralized and decentralized political structures."[38]

The main duty-bearers of human rights are the state parties to a treaty. However, human rights obligations apply to international actors, such as the World Bank, in relation to the humanitarian dimension of their projects and international co-operation

35 Hannan, M.A, 'Third Generation Human Rights and the Good Governance' [2010] OIDA International Journal of Sustainable Development 2 (5) 41-50

36 Vienna Declaration and Programme of Action 1993, art 5; Eide, A. supra note 7 at 31

37 International Covenant on Civil and Political Rights, supra note 31, art 2

38 UN Commission on Human Rights, *Note verbale dated 86/12/05 from the Permanent Mission of the Netherlands to the United Nations Office at Geneva addressed to the Centre for Human Rights ("Limburg Principles")* (E/CN.4/1987/17, 8 January 1987) para 46

too.[39] Based on the General Assembly of the United Nations 2002, in international law, the conduct of any organ of a state or non-organ that is empowered by the state to apply elements of governmental authority (exercising legislative, executive, and judicial or any other functions) is considered an act of that state. An organ includes any person or entity holding any position in the organization of a state or at any level of the government (central or territorial) that is given that status by national laws.[40] In recent years, the role of states has declined; the role of mixed actors, such as international financing and development institutions, the private sector, NGOs and regional and local governments has increased.[41] There are disagreements about the realization of human rights by non-state actors. For example, it is difficult for the private sector to respond effectively to the needs of disadvantaged groups of population. In this sector, administrative costs are often passed onto the insured and achieving cross-subsidization within a private individual-based system is not easy.[42] Traditionally, non-state actors are considered not to be bound by international human rights law because they are beyond the reach of these laws. Still, some non-legal enforcement mechanisms such as consumer boycotts and ethical investment strategies are suggested to induce human rights compliance.[43] Nevertheless, some obligations relating to the right to health, including refraining from interfering in people's enjoyment of their rights, should be fulfilled in both the private and the public sectors. The government is responsible for supporting the disadvantaged groups.

2.2.4 Compliance Evaluation at International Level

UN Committees of Independent Experts monitor the implementation of core human rights treaties. Each human rights treaty has its own monitoring body that meets regularly to review state parties' periodic reports and, through constructive dialogue with states, helps them to better fulfil their human rights obligations. States are required to make the reports available to their populations, according to the principle of transparency. Reports can contribute to the promotion of the debate on human rights issues, help the engagement of civil society, and encourage and facilitate public scrutiny of government policies. Following the review of a state's report, the

39 Dilys M. Hill, 'Rights and their Realization', in Beddard R. Dilys M. Hill (eds) *Economic, social and cultural rights: progress and achievement* (Macmillan in association with the Mountbatten Center for International Studies, University of Southampton 1992) 11

40 UN General Assembly, *Resolution A/RES/56/83 on Responsibility of States for Internationally Wrongful Acts* (2002) art 4-5

41 Eide, A. Rosas, A. supra note 32 at18

42 Langford, M. King A. J. 'Committee on Economic, Social and Cultural Rights; Past, Present and Future', in Langford, M. (ed) *Social Rights Jurisprudence: Emerging Trends in International and Comparative Law* (Cambridge University Press 2009) 508

43 Reinisch, A. 'the Changing International Legal Framework for Dealing with Non-State Actors' in Alston, P. *Non-state Actors and Human Rights* (Oxford University Press 2005)37-89

CESCR prepares Concluding Observations that include recommendations on how the state can improve its human rights record. States' compliance with the obligations of the ICESCR and the level of rights and duties are monitored by the CESCR. The Committee, essentially bases its judgment on national reports set by the state parties. However, the Committee is also entitled to make use of other information sources, such as the reports of national human rights NGOs. During the reporting process, indicators, national benchmarks, and realistic targets to be achieved in the next reporting period are identified by the Committee and the state.[44] The emphasis of the supervision is more on dialogue with states rather than on adversarial confrontation. The Committee cannot do more than asking or urging the states to correct the situation, when they are not fulfilling their obligations. There is no possibility of imposing fines or sanctions on states.[45]

2.3 HEALTH AS AN INTERNATIONAL CONCERN

Different threats to health, including transmissible diseases, poor sanitation, inadequate safe drinking water and lack of access to medical care, have been social concerns throughout history. The engagement of religious organizations such as churches, in providing healthcare and charity for the poor and the sick proves this concern. A long time ago, societies accepted the necessity of protecting health, whether for humanitarian, social or economic reasons. In1907, the Office International *d'Hygiène Publique* (English: International Office of Public Hygiene) was founded in Paris to administer international rules for the quarantining of ships and ports to prevent the spread of plague and cholera, and administer public health agreements.

In 1920, the League of Nations' Health Organization was established to prevent the spread of communicable diseases. Later, it was replaced by the World Health Organization (WHO). However, because it was poorly understood, for many years, the right to health has actually been marginalized in political and social debates around the globe. After the Second World War, humanitarian concerns, civil society's activities, domestic and regional political programs and global strategic considerations led to the inclusion of health in international law. At that time, health was considered

44 World Health Organization (WHO), *25 Questions & Answers on Health & Human Rights* (WHO, Health & Human Rights Publication Series, Issue No.1, 2002)4-16

45 Schoukens, P. 'The Right to Access to Healthcare: Healthcare According to International and European Social Security Law Instruments', in den Exter, A. P. (ed) *International Health Law Solidarity and Justice in Health Care* (Maklu, Antwerpen 2008) 24

necessary not as a "noble aspiration or utopian goal" but as an achievable goal.[46] The WHO has had an important effect on this process by defining what is meant by "health" and introducing the right to it.

2.3.1 What is Health?

The Constitution of the WHO (1946) conceptualizes health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[47] This definition has been influential in articulating the language of the right to health, and is included in several international human rights treaties.[48] It conveys a positive view of health rather than limiting it to the absence of disease or infirmity, and it includes the physical, mental, and social aspects of health. However, this definition has been subjected to controversy because it lacks an operational value, and it is not clear what the state of complete physical, mental and social well-being is. The ambiguity of the definition brings difficulties in measuring health status and the progress of its improvement. Another criticism is that such a broad definition turns all of human life and its political or economic difficulties into health problems.[49] In addition, the definition seems to be an ambitious and complex goal that requires an open-ended list of actions by multiple stakeholders to be applied.[50] It is also unrealistic to believe that everyone can be healthy. In addition to genetic impediments to the attainment of complete health by all, due to the increase of the burden of chronic diseases and the ageing of the world population, complete physical, mental and social well-being will not be achievable for many.[51] In addition, it is argued that this broad definition creates difficulties for both health professionals and policy makers to make it operational.[52] They need reasonable and workable standards to implement such a goal.

Other definitions have been suggested for health; but the definition of the WHO has been widely used. The CESCR believes that health requires more than medical care and that it depends upon the cultural, economic, social, civil, and political dimensions of life.[53] The inclusive definition of the WHO presents the effects of such factors on health. Considering such an aspirational and comprehensive definition for

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46 Tobin, J. *The right to health in international law* (Oxford University Press 2012) 14-36

47 Constitution of World Health Organisation 1948, Preamble

48 Toebes, B. *The Right to Health as a Human Right in International Law* (Intersentia 1999) 36.

49 Callahan, D. *The Roots of Bioethics: Health, Progress, Technology, Death* (Oxford University Press 2011) 63

50 Huber, M. Knottnerus, A. J. Green, L. van der Horst, H. Kromhout, D. et al. 'How should we define health?' [2011] BMJ 343:d4163

51 Yach, D. 'Health and illness: the definition of the World Health Organization' [1998] Ethik in der Medizin10 (1) 7-13

52 Ruger, J.P. *Health and Social Justice* (Oxford: Oxford University Press 2010) 122

53 UN Committee on Economic, Social and Cultural Rights, *Summary record of the 41st CESCR meeting* (E/C.12/1993/SR.41, 12 September1993.Palais des Nations, Geneva) 4

global plans appears appropriate. WHO has introduced specific targets and indicators to resolve measurement issues related to its definition of health.[54]

Health is recognized in international laws and policy documents related to development, health and human rights. The Alma Ata Declaration (1987) is well known for addressing the main health problems in communities and promoting primary healthcare as a means to advance equitable access to all levels of health services.[55] In September 2000, the Millennium Declaration was adopted by the UN members. In this Declaration, the world's leaders committed to a wide range of programs and action plans for combating poverty, hunger, diseases, illiteracy, environmental degradation and discrimination against women. Moreover, the adoption of General Comment No. 14 ICESCR on the right to health was a significant step toward understanding the right to health.[56] In 2005, WHO members committed to universal health coverage to guarantee everyone's access to essential health services without any risk of financial ruin or impoverishment. This initiative has resulted in considerable advancement in the provision of health services and in financial risk protection.[57]

2.3.2 Right to Health

The first notion of a legal right to health (mentioned as medical care) under international law can be found in the Universal Declaration of Human Rights (1948). Article 25 of this Declaration indicates that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services".[58] The linkage between human rights and health has been one of the considerable advances in the history of health. However, the Declaration does not define the components of a right to health. The ICESCR defined the right to health and determined a short list of steps for the realization of this right. Later, this right was recognized by several international human rights treaties such as Article 5 (e) (iv) of the International Convention on the Elimination of all Forms of Racial Discrimination (1965), Articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women (1979), Article 24 of the Convention on the Rights of the Child (1989)and Article 25 of the Convention on the Rights of People living with Disabilities (2006).

54 Yach, D. supra note 51

55 World Health Organization, *The World Health Report 2013; Research for Universal Health Coverage* (WHO, 2013) 6

56 UN Committee on Economic, Social and Cultural Rights(CESCR), *General Comment no. 14 ICESCR, The Right to the Highest Attainable Standard of Health* (2000) paras 4&17

57 WHO, *Resolution WHA58.33. Sustainable Health Financing, Universal Coverage and Social Health Insurance*. (In: Fifty-eighth World Health Assembly, Geneva, 16–25 May 2005. Volume 1. Resolutions and decisions. Geneva, World Health Organization, 2005 (Document WHA58/2005/REC/1)).

58 Universal Declaration of Human Rights 1948, supra note 18, art 25.1

Moreover, several regional human rights instruments recognized the right to health. Examples are Article 11 of the European Social Charter of 1961, Article 16 of the African Charter on Human and Peoples' Rights of 1981, Article 10 of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 and Article 17 of the Cairo Declaration of Human Rights in Islam (1990).

Article 12 of the ICESCR defines the right to health as "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".[59] The manner in which a state frames a right determines the type and amount of resources that will be allocated to realize that right. The right to health can be defined differently, ranging from avoiding interference in people's enjoyment of their right to health to taking minimal actions, such as the provision of primary healthcare for the poor, or taking extensive actions, such as providing shelter and food, or empowering individuals to make decisions about their own health.[60] According to General Comment no. 14 of the ICESCR, the right to health is not a right to be healthy or a right to perfect health, and states cannot ensure good health for everyone, nor can governments protect people from every cause of ill health. The right to health is a right to the enjoyment of facilities, services and products related to health and its underlying determinants that provide the necessary conditions for the enjoyment of the highest attainable level of health. The right to health includes a right to equal and timely access to basic preventive, curative, and rehabilitative health services, essential drugs, and regular screening programs. It also includes the appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, and appropriate mental health care.[61]

The right to health is driven from the inherent worth and dignity of human beings; it is related to and dependent upon the realization of other human rights, such as the right to life, human dignity, non-discrimination, equality, food, education, work, and housing, and the prohibition of torture. This right encompasses a set of socio-economic factors that provide the conditions for people to have a healthy life. This right includes the right to the underlying determinants of health such as food, housing, safe and potable water and appropriate sanitation, safe and healthy working conditions, and a healthy environment. Health-related education and information and participation in health-related decision-making are parts of this right too. The right to health encompasses the right to control one's health and body and to be free from interference, torture, and non-consensual medical treatment and experimenta-

59 International Covenant on Economic, Social and Cultural Rights (ICESCR), supra note 33, art 12

60 Harvard Law School, *Economic and Social Rights and the Right to Health; an Interdisciplinary Discussion* (Massachusetts, September 1993) 3

61 *General Comment no. 14 ICESCR, supra note 56,* paras 4&17

tion and the right to a system of health protection that provides equal opportunity for everyone to enjoy the right to health and the underlying determinants of health.[62]

2.3.3 States' Obligations Concerning the Right to Health

Currently, most countries have accepted at least one of the international or regional covenants or treaties recognising the right to health. 160 countries ratified the ICESCR and 135 countries incorporated the right to health or duties of the state with respect to people's health into their constitution by 2009.[63] Governments decide freely whether to join an international treaty; as soon as they make this decision, there is a commitment to act in accordance with the provisions of the treaty.[64] Based on the Vienna Declaration and Program of Action in 1993, all states, regardless of their economic, political and cultural systems, are to promote and protect all fundamental human rights and freedoms.[65] National and regional specifications and different historical, cultural and religious backgrounds might affect how the rights are realized but not the content of rights. States are required to provide a minimum level of every right for everyone and then to improve the situation of each right. The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights (1997)indicate that "steps towards the full realization of rights must be deliberate, concrete and targeted as clearly as possible towards meeting a government's human rights obligations. All appropriate means, including the adoption of legislative measures and the provision of judicial remedies as well as administrative, financial, educational and social measures must be used in this regard."[66] States are required by Article 12 of ICESCR to take the following steps in realization of the right to health:

a. The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child; (according to General Comment no. 14 ICESCR, recently, infant and under-five mortality rates are measured instead of stillbirth rate.[67])
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 everyone's access to all medical services and medical attention in the event of sickness.[68]

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62 Ibid, paras 3&8
63 Hogerzeil, H. V. Mirza, Z. *The World Medicines Situation 2011, Access to Essential Medicines as Part of the Right to Health* (WHO Department of Public Health, Innovation and Intellectual Property, Geneva, 2011) 6-7
64 World Health Organization (WHO) supra note 44 at 12
65 Vienna Declaration and Programme of Action 1993, art 5
66 *Maastricht Guidelines on Violations of Economic, Social and Cultural Rights* (1997) part II
67 General Comment no. 14 ICESCR, supra note 56, para 14
68 ICESCR, supra note 33 at 12

Based on the obligation of respect, states are required to refrain from denying or limiting the enjoyment of people of the right to health and its underlying determinants. The obligation to protect necessitates that states employ all essential means to prevent third parties from interfering in people's enjoyment of their rights. The obligation to protect is rooted in concern for the enhanced role of the private sector in societies.[69] States are required to regulate, inspect and monitor private parties' conduct and to consider enforcing administrative and judicial sanctions against non-compliant third parties, such as employers, healthcare providers, private food and water suppliers and, potentially polluting industries.[70] The obligation to fulfil includes duties of the states to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures toward the full realization of the right to health.[71]

The obligation to fulfil contains obligations to facilitate, provide and promote. The obligation to facilitate requires states to establish conditions that enable individuals and communities to enjoy their right to health. In this respect, necessary means including appropriate legislation and a national strategy and plan of action for the realization of the right to health should be adopted and implemented. In addition, the states should ensure that relevant systems, such as social security and health systems are adequate and accessible to the entire population. To fulfil the obligation to promote, states are required to create, maintain and restore the realization of rights by appropriate education and public awareness. Based on the obligation to provide, the state should provide means for individuals and groups who are unable to realize their rights because of conditions that are accepted as being beyond their control. Examples include the poor or people belonging to lower-income groups, disadvantaged and marginalized women, persons living with disabilities, asylum seekers, refugees and internally displaced persons, the elderly, children, indigenous people, minorities, and the homeless.[72] States are required to identify problematic situations, provide relief, and create conditions for right-holders to access the provisions protected by law. The obligation to fulfil can consist of the direct provision of basic needs, such as food when there is no other possibility to access it, for example in the

69 *Maastricht Guidelines on Violations of Economic, Social and Cultural Rights* (1997) supra note 66, para 18; General Comment no. 14 ICESCR, supra note 56, para 33

70 Saul, B. Kinley, D. Mowbray, J. *The International Covenant on Economic, Social and Cultural Rights* (Oxford University Press, 2014) 631

71 General comment no. 14 ICESCR, supra note 56, para 33

72 UN Committee on Economic, Social and Cultural Rights, *General Comment no. 19 ICESCR: The Right to Social Security* (2008) paras 48-50

case of unemployment or during recessions, crisis or disasters, for disadvantaged and marginalized groups and individuals.[73]

According to General Comment no. 14 of the ICESCR, health (and its underlying determinants) facilities, services and products should be available, accessible, acceptable to everyone, and of appropriate quality (AAAQ). Availability requires that health facilities, services and products be provided in sufficient quantity throughout the country's jurisdiction. An adequate number of skilled medical personnel, scientifically approved and unexpired medicines and hospital equipment, safe water, and sanitation should be provided to everyone without any types of discrimination. Accessibility includes the four dimensions of non-discrimination, physical and financial accessibility and information availability. Health facilities, services and products should be accessible to everyone, particularly the most vulnerable and marginalized groups of the population and individuals. In addition to prohibiting discriminatory practices, the legislation should contain special measures granting protection to vulnerable or disadvantaged groups, such as children and indigenous people. Health facilities, services and products should be physically accessible and within a safe physical reach of everyone including women, the elderly, children, indigenous people, and persons living with disabilities or HIV/AIDS. Appropriate incentives should be offered to attract physicians and other healthcare providers to deliver services in underserved geographic areas.[74]

Moreover, whether privately or publicly provided, health facilities, services and products should be affordable for all; states have an obligation to support those who lack sufficient means to enjoy their right to health.[75] It is a principle that no one who needs healthcare should be denied because of inability to pay.[76] To fulfil this goal, the WHO suggested that there should be no out-of-pocket payments above a given threshold of affordability. That threshold is usually set at zero for the most disadvantaged and the poorest individuals and groups of population.[77] In addition, information about health issues and the right to health should be accessible to everyone. People should have the opportunity to seek, receive and impart information and ideas concerning health issues. Acceptability requires the government to ensure that all health facilities, services and products are culturally appropriate and respectful of medical ethics. Finally, all health facilities, services and products should be of good quality and scientifically and medically appropriate.[78]

73 International Commission of Jurists, *Courts and the Legal Enforcement of Economic, Social and Cultural Rights, Comparative Experiences of Justiciability* (International Commission of Jurists, Geneva,2008) 53

74 World Medical Association Statement on Access to Health Care *2006,* art 34

75 General comment no. 14 ICESCR, supra note 56, para 12

76 World Medical Association Statement on Access to Health Care, supra note 74, art 34

77 World Health Organisation, supra note 55, at 7

78 General comment no. 14 ICESCR, supra note 56, para 12

2.3.4 Minimum Core Content of the Right to Health Obligations

The definitions of health and the right to health are very broad; consequently, state obligations are broad and costly. However, such challenges do not mean that low income countries cannot realize this right because they do not have the resources to provide expensive health services. Parts of the right to health can be realized at a low cost. In addition, states are required to make policies and action plans that will progressively lead to accessible healthcare for all in the minimum time possible.[79] Every state has specific conditions and capabilities, such as human and financial resources, transportation systems and public education. In addition, the health situation of populations and their needs and demands are different. These factors influence the approach of a country and the priorities for the realization of the right to health.[80] Governments should allocate health the sums it deserves from the national budget. Priority should to be given to prevention and cost-effective health services.[81]

A primary obligation of state parties to the ICESCR concerning the right to health is to ensure minimum health conditions for all and thereafter to progressively improve these conditions to achieve the highest attainable standard of physical and mental health for all. Based on General Comment no. 14 of the ICESCR, core obligations relating to the right to health are providing universal access to health facilities, services and products (including reproductive, maternal and child healthcare, essential medicine, immunization and health information), minimum essential food, basic shelter, sanitation and safe water.[82] Minimum core obligations are the first step in realizing ESCRs. According to the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights "such minimum core obligations apply irrespective of the availability of resources of a country concerned or any other factors and difficulties."[83] General Comment no.3 of the ICESCR on the nature of states parties obligations indicates that "a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party. Thus, for example, a state party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary healthcare, of basic shelter and housing, or of the most basic forms of education is, prima facie, failing to discharge its obligations under the Covenant."[84] To fulfil the minimum core

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79 World Health Organization (WHO), supra note 44, at 9

80 World Medical Assembly Statement on Access to Health Care, supra note 74, Preamble

81 United Nations Committee on Economic, Social and Cultural Rights(CESCR), *Summary record of the forty-second meeting*, 6 December 1993(C.12/1993/SR.42, 1994) 49

82 General Comment no. 14 ICESCR, supra note 56, Paras 43-44

83 Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, supra note 66, para 9

84 UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment no. 3 ICESCR: The Nature of States Parties' Obligations* (1990) para 10

obligations of the right to health for all, a health sector paradigm should follow these objectives:

- Providing basic standards of health to everyone in the country in an equal manner,
- Removing existing inequities in the distribution of health sector resources and bringing disadvantaged groups up to mainstream levels,
- Considering health services as a public good and not treating them as a profit-making commodity,
- Recognition of legally enforceable entitlements of individuals and provision of low-cost and accessible mechanisms for people to seek for remedies in the case of violations of their right to health,
- Facilitating participation of individuals and groups in priority setting and monitoring of health sector activities and financing healthcare.[85]

2.3.5 Progressive Realization

According to the ICESCR, states are required to use the maximum available resources to progressively realize ESCRs, including the right to health.[86] Because of the differences in available resources and the population's health situation in different countries, it is difficult to set universally applicable standards and obligations for all. Every country should define national benchmarks for ESCRs in accordance with the full range of obligations and maximum available resources.[87] In the development of a right to adequate healthcare, a poor and a rich country might have different benchmarks. However, some rights, such as freedom from discrimination are not progressive and no matter where they are practiced, constitute universal standards for all countries. Progressive realization indicates that states can decide what steps to take to address ESCRs obligations as long as they reflect constant progress. An implication arising from progressive realization is that at least the present level of enjoyment of rights should be maintained.[88] Progressive realization requires all countries to move as expeditiously and effectively as possible toward full realization of rights.[89]

Not all obligations of the ICESCR are progressive; some of them are immediate. Examples are equal treatment of men and women and the prohibition of discrimination, the prohibition against adopting retrogressive measures in the realisation of

85 United Nations Committee on Economic, Social and Cultural Rights, supra note 81, at 49

86 ICESCR, supra note 33, art 2

87 Office of the UN High Commissioner for Human Rights, *Economic, Social and Cultural Rights; Handbook for National Human Rights Institutions* (Professional Training Series No.12, UN, New York and Geneva, 2005)66

88 UN Human Rights Council, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt* (A/HRC/7/11, 31 January 2008) part 8

89 World Health Organization, supra note 44, at 16

rights and the obligation to meet minimum core obligations. In addition, some rights, which can be characterized as freedoms, should be realized immediately. For example, freedom from inhumane treatment and forced medical examinations or sterilization is of immediate effect and is not related to the availability of resources. The same is applicable to the protection of individuals from third parties' interference in the enjoyment of their rights.[90] When a retrogressive measure is taken, the state should provide evidence of careful consideration of all alternatives and maximum available resources. When resource constraints make it impossible for the state to fulfil its obligations, the state should provide evidence that every effort has been made to maintain the current level of the rights. However, according to General Comment no. 14, non-compliance with the core obligations of the right to health cannot be justified under any circumstances. In the case of economic crisis and severe financial limitations, there is the possibility to seek help from the international community.[91]

Even though, the notion of using the maximum of available resources is relevant to both poor and wealthy countries, it has different implications for each; a rich country should have a higher standard than a low- or middle-income country.[92] All countries should show that they are willing to realize the right to health and to make constant progress toward the full realization of this right. Moreover, not all elements of the right to health demand considerable resources. Many important measures to protect and promote the right to health are not expensive and can be adopted by all countries, no matter what their level of economic development is. For example, even with very limited resources, discrimination can be addressed by appropriate guidelines.[93]

In the allocation of resources more emphasis should be given to preventive services compared with expensive medical procedures and priority should be given to primary or community healthcare facilities rather than high technology and capital-intensive ones.[94] In addition, the special needs of the most disadvantaged and vulnerable groups should be met first. As a state takes retrogressive measures in realisation of rights, it is important to distinguish between the inability and the unwillingness of the state to fulfil the obligations. The CESCR has promulgated measures to examine a country's justification of unavailability of resources for adopting retrogressive measures. These measures include assessing the severity of the alleged breach, the proximity of the minimum essential level of the right, the level of the country's development and economic situation, whether the country has sought low-cost alter-

90 Office of the UN High Commissioner for Human Rights, supra note 87, at 11
91 General Comment no. 14 ICESCR, supra note 56 para 38
92 UN General Assembly, *Implementation of General Assembly Resolution 60/251 of 15 March 2006 entitled "Human Rights Council"* (A/HRC/4/28, 17 January 2007) 15
93 Committee on Economic, Social and Cultural Rights, supra note 53, at 8
94 United Nations Committee on Economic, Social and Cultural Rights, supra note 81, at 49

natives and international co-operation and assistance to maintain its current level of rights, whether the measures are discriminatory, and whether a lack of resources will have a constant effect on the realization of the right.[95]

2.3.6 Non-discrimination and Human Rights

Endeavours to promote equality of human beings received attention when poor workers in life threatening workplaces protested against landowners and local lords before the Industrialization era, a time when poverty and unequal access to resources were accepted as realities of life for specific groups of society.[96] The United Nations' Charter is the first international treaty that affirmed "faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women".[97] Later, Article 25 of the Universal Declaration of Human Rights recognized the equality of all human beings in dignity and rights.[98]

Governments are required by two Human Rights Covenants (ICCPR and ICESCR) to prevent any discrimination on internationally prohibited grounds including race, colour, sex, language, religion, property, national or social origin, political or other opinion, birth or other status in the enjoyment of fundamental rights, such as access to healthcare and underlying determinants of health.[99] However, disparities in access to the necessities of life between men and women, children and elderly people, poor and rich, villagers and urbanites and citizens and refugees can be observed throughout the world. The differences are larger for advanced healthcare than for primary healthcare. People belonging to lower socio-economic groups are more likely to have higher rates of disease, disability and death. They often use fewer health services than they need and might be required to pay a disproportionately higher share of their income for health services.[100] Frequently, it has been reported that the poor have more health needs than the well-off. In addition, disadvantaged and poor groups are vulnerable to other abuses of their human rights. The main roots of poverty are unemployment and insufficient income which are frequently associated with illiteracy and ill-health. Poor people do not have power or political

95 General Comment no. 19 ICESCR, supra note 72, para 42

96 Haxhiraj, A. supra note 9

97 Charter of the United Nations 1945, supra note 14, preamble

98 Universal Declaration of Human Rights, supra note 18, art 1

99 International Covenant on Civil and Political Rights supra note 31, art 2; ICESCR, supra note 33, art 2

100 de Looper, M. Lafortune, G. *Measuring Disparities in Health Status and in Access and Use of Health Care in OECD Countries* (OECD Health Working Papers, No. 43, OECD Publishing, Paris, 2009) 3

tribunals; thus, in case of disaster, famine or environmental pollution, they are the first to suffer.[101]

Discrimination is defined by General Comment no. 20 of the ICESCR as "any distinction, exclusion, restriction or preference or other differential treatment that is directly or indirectly based on the prohibited grounds of discrimination and which has the intention or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing of Covenant rights."[102] According to the WHO, health systems are often inequitable, providing higher quality and more services to the rich, who need them less, than to the poor, who need more and are unable to obtain them. In the absence of measures to ensure disadvantaged groups are effectively reached by the health system, such inequalities will continue.[103] Inequity is an unnecessary and avoidable difference in access to available care for equal need. Unequal treatment of equal cases is discrimination.[104] According to the CESCR, through the adoption, modification or abrogation of legislation, discrimination related to health and its underlying determinants can be eliminated with minimum resource implications. Based on General Comment no. 3 ICESCR on the nature of state parties' obligations, the vulnerable groups of society should always be protected, even in times of severe shortage of resources, through the adoption of relatively low-cost targeted programs.[105] A range of techniques have been used to improve the access of the poor to necessary services. They include adopting proper means for identifying poor individuals, cash payments for the use of services, and use of non-governmental organizations to provide pro-poor services.[106]

2.3.7 Health System and the Right to Health

Since people began to protect their health and treat diseases, some types of health system have existed. However, organized health systems have not existed further back than approximately 100 years ago, even in the developed world. They have gone through several developments and reforms and have been framed by national and international values and goals. According to the WHO, currently, health systems in many countries are failing and collapsing. Health services are often accessible to

101 Hausermann, J. 'The Realization and Implementation of Economic, Social and Cultural Rights', in Beddard R. Dilys M. Hill (eds) *Economic, Social and Cultural Rights: Progress and Achievement* (Macmillan in association with the Mountbatten Center for International Studies, University of Southampton, 1992) 57

102 UN Committee on Economic, Social and Cultural Rights, *General Comment no. 20 ICESCR: Non-Discrimination in Economic, Social and Cultural Rights* (2009) para 7

103 Gwatkin, DR. Bhuiya, A. Victora, CG. 'Making Health Systems More Equitable' [2004] Lancet 364 (9441) 1273-1280.

104 Whitehead, M. 'The Concepts and Principles of Equity and Health' [1992] International Journal of Health Services 22, 429-445

105 General Comment no. 3 ICESCR, supra note 84, para 12

106 Gwatkin DR, Bhuiya A, Victora CG. Supra note 103

certain groups of the population. Many health systems are unsafe, inequitable and regressive and health outcomes are much lower across many developing countries. Moreover, deep inequities in health status persistently exist worldwide. Failure of health systems is at the centre of this problem.[107] In addition, human rights principles are not considered in most health-system reforms, and the reforms tend to focus on market policies.[108] This approach prioritizes expensive procedures, such as complicated surgeries needed by small parts of the population, over cheap prevention services needed by a larger part of the population because the financial benefits of expensive procedures are greater than those of preventive services. In addition, the focus of health systems is mostly on diseases rather than on the person as a whole, whose mind and body are linked and should be treated with respect and dignity.[109]

Demand for healthcare always exceeds supply, and as a result, there will be people requiring necessary care but not having access due to a lack of resources. Nowadays, efficiency is one of the main aims of healthcare system reforms to respond to patients' increasing needs for medical care and the scarcity of resources.[110] The problem with healthcare rationing is that in a system of implicit rationing, individuals with lower socio-economic status inevitably fall victim to inequality which is a violation of human dignity. It is important to make choices that benefit a larger population. The example is the vaccination of newborns instead of an expensive artificial hearts for the elderly.[111] Currently, governments are considering whether specific expensive therapy or medicine covered by national healthcare benefit package should be provided. In the most extreme cases, it even can result in death for patients with life- threatening diseases.[112] It is important that minimum standards and human rights conventions be considered as standard setting instruments in making health policies.[113] In this system, decisions need to be the result of comprehensive, systematic, rational and transparent deliberation. Moreover, they should be verifiable, visible, and legitimized in a democratic manner.[114]

Another suggested solution for tackling the problems of scarcity of resources is to introduce competition into healthcare. However, concerns about the benefits of

107 Ibid

108 San Giorgi, M. *The Human Right to Equal Access to Health care* (The Netherland: Intersentia; 2012) 1

109 World Health Organization, *People at the Center of Health Care* (WHO, Geneva, 2007) 7

110 den Exter, A. ' Access to healthcare; solidarity and justice' [2008] Med Law 27, iii-vi

111 Buijsen, M. 'the special moral status of health care. on market forces, equal treatment, and having a say' in den Exter, A. Buijsen, M.(eds) *Rationing Health Care: Hard choices and unavoidable trade-offs* (Maklu, 2012)197-208

112 den Exter, A. 'Cost-effectiveness analysis: What's law got to do with it?' [2014] Medicine and Law 2(2) 249-297

113 den Exter, A. supra note 110

114 Buijsen, M. supra note 111

efficiency and equity should be addressed together.[115] Privatization can be justified for economic reasons such as cost–reduction and improvement of efficiency. But it is necessary to regulate health systems to respect fundamental human rights and principles such as equal access to healthcare and the equality of persons and solidarity.[116] Traditionally, solidarity and equal access are the basis of health insurance systems. Buijsen indicates that "solidarity refers to actual understanding of union and commitment and subsequent willingness to share the risks inherent to human existence."[117] The key principle in healthcare systems should be solidarity. It means that everyone should have access to healthcare based on medical needs, not ability to pay.[118] Human rights law introduces a unique and uncompromising notion of justice in the field of health care. Distribution of health care is distribution on the basis of need.[119] Justice and equality are very important in the field of healthcare. Equality in healthcare entails equal material opportunities; it only exists in the sphere of justice. The intrinsic value of health as a goodness compels demand for equal access to health system resources.[120] The shift towards a competitive health insurance market and freely negotiated prices and premiums that are not based on people's income will serve the wealthy more than the poor population. In this situation, the poor are less likely to take basic or supplementary insurance coverage because of an inability to afford it.[121]

The right to the highest attainable standard of health is the right to an integrated and effective health system that includes health and its underlying determinants, provides equal access for everyone and is responsive to national and local priorities.[122] The essential components of an effective health system relevant to both developed and developing countries suggested by the Alma Ata Declaration are equity, community participation, a multi-sectoral approach to health problems, effective planning, integrated referral systems, health-promotional activities, trained human resources, and international co-operation.[123]

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115 den Exter, A. Guy, M. J. 'Market competition in health care markets in the Netherlands: some lessons for England?' [2014] Medical law review *22*(2) 255

116 den Exter, A. 'Health system reforms in the Netherlands: from public to private and its effects on equal access to health care' [2010] Eur. J. Health L 17, 223

117 Buijsen, M. 'the meaning of Justice and solidarity in healthcare', in den Exter, A. (ed) *International health law solidarity and justice in healthcare* (Maklu, 2008)51-61

118 Jost, T. S. Dawson, D. den Exter, A. 'The role of competition in health care: A western European perspective' [2006] Journal of Health Politics, Policy and Law 31(3) 687

119 Buijsen, M. 'The Meaning of Justice in Health Care [2008] *Med & Law 27*, 535

120 Buijsen, M. den Exter, A. 'Equality and the right to healthcare'. in den Exter, A. (ed) *Human rights and Biomedicine* (Maklu, 2010) 69-85

121 Buijsen, M. "'Market reforms and health care access in the Netherlands" [2015] Bioethica Forum. Schweizer Zeitschrift für Biomedizinische Ethik 3, 100

122 UN General Assembly supra note 92, at 15

123 Alma Ata Declaration 1987, part VII

For a country that is willing to realize the right to health, having a national strategy and action plan with a timeframe for the achievement of the goals and possible resources and procedures are necessary. Appropriate feasible measures for the realization of the right to health are different for every state. The national health policy should be accompanied with detailed plans for realizing the right to health, including safe motherhood, immunization programs, reproductive health services, safe food, potable and clean drinking water, basic sanitation, healthy lifestyle, and adequate living conditions. Moreover, it should be responsive to new health challenges, such as the spread of HIV/AIDS, and to underlying determinants of health, such as domestic violence and environment pollution. Furthermore, states are required to provide affordable health insurance for all. Accountability, transparency, participation, collaboration with civil society and non-discrimination should be considered, and a legal framework to implement and monitor the national strategy should be advised.[124] To make such a plan and monitor its implementation, having an appropriate health information system is essential. Data on the situation of health and its underlying determinants should be regularly collected, analysed and published. Statistics should be disaggregated by factors such as age, gender and place of residence to ensure that any inequitable effect of the programs on specific groups can be monitored and corrected.[125]

Depending upon financial capabilities and technology and knowledge availability, the precise practical application of the requirements of ICESCR on the right to health can vary from one state to another. In addition, the causes of ill-health differ from one country to another. Each state should determine its own priority health problems and decide which services are needed to address the problems.[126] This system should include appropriate indicators and benchmarks to make progressive realization possible. The national policy should include measures for producing a sufficient number of well-trained health workers, right-to-health impact assessments means, "bottom-up" participation in the policymaking process and accessible mechanisms of accountability.[127] According to the High Commissioner for Human Rights, the achievement of the highest attainable standard of physical and mental health requires the co-operation of several social, economic and health sectors. Key means for the full realization of the right to health are good governance, sound economic policies and well-founded democratic institutions that are responsive to people's needs.[128]

124 Ibid at para 55
125 General Comment no. 14 ICESCR, supra note 56, paras 36-37
126 World Health Organisation, supra note 55 at 8
127 General Comment no. 14 ICESCR, supra note 56, part 4
128 UN Commission on Human Rights, *Resolution no. 2004/27 on The right of everyone to the enjoyment of the highest attainable standard of physical and mental health* (2004) 4

Human rights, including the right to health, require the establishment of effective, transparent and accessible mechanisms of accountability. Accountability should not be used as a means for blaming and punishment but as a process to determine what in the system works (so that it can be repeated) and what does not (so that it can be adjusted). There are many forms of accountability, ranging from a free press to inquiries by national human rights institutions, court processing or administrative impact assessments. Within each state, there should be a range of accountability mechanisms. The form does not matter, as long as it is suitable for a country.[129] In some countries, the right to health has been given effect before domestic courts. Most successful court cases involved a right to certain healthcare services and environmental health, non-discrimination in access to rights in the private sector and arbitrary denial of access to healthcare and social benefits.[130] Discriminatory refusal of healthcare services is one of the cases that has received considerable attention by the CESCR.[131] Without accountability, a state might use a shortage of resources as an excuse to do nothing or to respond primarily to the demands of interest groups with the "loudest voices". Independent, effective and accessible mechanisms of accountability urge a state to explain its policies and actions toward the realization of the right to health for all.[132] It should not be used as "window dressing".

To successfully implement plans related to the right to health, everyone working in the fields of public health and medical care including community health workers, health professionals, policymakers, economists and administrators should be engaged in the health and human rights movement.[133] Human rights education and training should be integrated into all levels of the professional education system. National healthcare professional associations should enhance the awareness of their members about human rights and demand them to respect people's rights. Everyone working in health-related sectors, including the staff of the ministries of health, should become familiar with the legal perspective of the right to health and its necessities in all health programs.[134] These days, the role of individuals in a healthcare system and health insurance is changing from passive consumers towards active participants claiming their rights.[135]

129 UN Human Rights Council, supra note 88, at 13-15

130 Langford, M. 'The Justiciability of Social Rights: from Practice to Theory' in Langford, M. (ed) *Social Rights Jurisprudence: Emerging Trends in International and Comparative Law* (Cambridge University Press, 2009) 17

131 Langford, M. King A. J. supra note 42, at 485

132 UN General Assembly, supra note 92, at 21

133 UN Commission on Human Rights, supra note 128, at 4

134 UN General Assembly supra note 92, at 14

135 Wildner, M, den Exter, A. P. van der Kraan, W. G. 'The changing role of the individual in social health insurance systems' in Saltman, B. R. Busse, R. Figueras, J. (eds) *Social health insurance systems in Western Europe* (European Observatory on Health Systems and Policies Series, Open University Press 2004) 248.

Patients' rights developments might increase the costs and threaten the solidarity and financial sustainability of healthcare system. It can be compensated for by empowering healthcare consumers to participate in decisions and by promoting accountability in the system.[136] people should be empowered at three levels: participation in national development by assertion of rights and representation, consultations on decision making and giving them freedom of choice, and involvement in treatment decisions, and administrative redress.[137] A change in individual responsibility is necessary when implementing healthcare reforms with a human rights approach. It will lead to better protection of individual rights and will preserve the sustainability of healthcare systems.[138]

2.4 CONCLUSIONS

The above explanations of the nature and key aspects of health and the right to health at international level provide an insight into the realisation of this right and examination of a specific country case study in Part III. The right to health is a firmly established part of binding human rights law. Human rights treaties have clarified the scope and content of the right to health and translated the definition of health, provided by the WHO into operational policies and programs. The examples are General Comment no. 14 ICESCR on the right to the highest attainable standard of physical and mental health, and General Comment no. 15 of the Convention on the Rights of the Child (CRC) on children's right to health. According to these documents, State parties are required to use all necessary means including legislative and judicial measures for the realisation of this right. The next chapter establish a platform for analyzing the justiciability of this right at the international, regional and national levels.

136 den Exter, A. 'Purchasers as the public's agent' in Figueras, J. Robinson, R. Jakubowski, E. (eds) *Purchasing to improve health systems performance* (McGraw-Hill Education (UK) 2005)122-139

137 Wildner, M, den Exter, A. P. van der Kraan, W. G. supra note 135

138 Liu, Z. Buijsen, M. 'Reaffirming Individual Responsibility in Distributive Justice: A Case Study of the Chinese Healthcare System' [2017] *Int'l J. Soc. Sci. Stud. 5*, 14