

# THE INTERNATIONAL HUMAN RIGHT TO HEALTH: WHAT DOES THIS MEAN FOR OUR NATION AND WORLD?

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## INTRODUCTION

Throughout my career, I have searched for ways to compel access to needed health services of all types for all people in need. My search would be simple if there were a legal mandate in some source of law that required societies through their governments to assure adequate and affordable health care services. Unfortunately, at least in the United States, the right to health is not generally a legal right. Thus, whether one recognizes a right to health depends on one's political persuasion and moral values. In other words, a "right to health" is an option.

But international human rights law—which is now in the course of astonishing and rich development—may provide a legal mandate for a right to health in the United States and other nations. This is the subject of my paper: What does the international human right to health mean for the United States and the world?

What is the "right to health?" This preliminary issue is the subject of much debate. I will talk more about this issue later. But for now, a right to health could be understood on a continuum. At a minimum, it could mean a right to conditions that protect health in the population. It might also include civil and political rights with respect to access to population-based and personal health care services. At most, it could also include provision of medical care for the diagnosis and treatment of disease and injury for those unable to pay.

Defining the content of a right to health is a formidable challenge. But the challenge should not impede the recognition and development of a human right to health in international human rights law. For such definitional problems attend many human rights and particularly those affirmative economic, social and cultural human rights that are now coming into their own in the post-Cold War World.

The idea of an international human right to health is gaining attention and currency throughout the world today.<sup>1</sup> For example, in 1998, a Consortium of

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1. See, e.g., LAWRENCE O. GOSTIN & ZITA LAZZARINI, HUMAN RIGHTS AND PUBLIC HEALTH IN THE AIDS PANDEMIC (1997); HEALTH AND HUMAN RIGHTS: A READER (Jonathan M. Mann ed., 1999); BRIGIT C.A. TOEBES, THE RIGHT TO HEALTH AS A HUMAN RIGHT IN INTERNATIONAL LAW (1999); Rosalia Rodriguez-Garcia & Mohammad N. Akhter, *Human Rights: The Foundation of Public Health Practice*, 90 AM. J. PUB. HEALTH 693 (2000); Virginia A. Leary, *The Right to Health in International Human Rights Law*, 1 INT'L J. HEALTH & HUM. RTS. 25 (1994); Brigit Toebes,

United States Human Rights Organizations sponsored programs to heighten awareness of human rights and health in honor of the fiftieth anniversary of the UN Universal Declaration of Human Rights.<sup>2</sup> Also, high visibility human rights cases such as the attempted extradition of General Agosto Pinochet of Chile and the work of non-governmental organizations (NGOs) such as Amnesty International and Human Rights Watch have heightened international awareness of human rights generally throughout the world.

However, U.S. health policy makers do not look to international human rights law for mandates or guidance when it comes to domestic health policy. In fact, it would probably surprise many U.S. health policy makers that a body of international law exists that has concrete implications for domestic policy making regarding health.

I would like to offer some ideas about how the international human right to health, established in a variety of sources of international human rights law and general international law, creates a right to health services in the nations of the world. Specifically, this body of law requires nation states to take affirmative steps to assure that residents of the country have access to population-based health protection measures and also affordable health care in the context of the nation's economic resources and cultural mores.

In this Article, I will lay out the sources of international law that establish a human right to health for all people. Second, I will suggest ideas for the implementation of a right to health throughout the world. Third, I will offer observations about the potential impact of full recognition of the international human right to health on the people of all nations, including the United States.

## I. SOURCES OF INTERNATIONAL HUMAN RIGHTS LAW

Notions of human rights are not new. The idea that individual human beings have human rights has its origins in the world's religions that recognize two basic precepts: (1) God, however revealed, values all human beings, and (2) human beings, in turn, are accountable to God for their actions toward other human beings whomever they may be.

We generally attribute the origins of modern notions of human rights to the Eighteenth Century Enlightenment and the English Revolution of the Seventeenth Century. The legacy of the Eighteenth Century Enlightenment and the English, American and French Revolutions was recognition of civil and political human rights for all people primarily in relation to their governments. The Eighteenth Century Enlightenment did recognize one economic right, the right to property, which served as the basis of the emerging economic system of capitalism in the Industrial Revolution.

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*Toward an Improved Understanding of the International Human Right to Health*, 21 HUM. RTS. Q. 661 (1999).

2. See George J. Annas, *Human Rights and Health—The Universal Declaration of Human Rights at 50*, 339 N. ENG. J. MED. 1777 (1998); Consortium for Health and Human Rights, *Health and Human Rights: A Call to Action on the 50th Anniversary of the Universal Declaration of Human Rights*, 280 JAMA 462 (1998).



Economic rights, in particular the human right to health, have different origins. They emerged primarily from the economic dislocations of the Industrial Revolution, which inspired many philosophers, including Karl Marx, to conclude that human beings also have rights to economic security. Notions of a positive right to health had its origins in the Sanitary Revolution of the Nineteenth Century when public health reformers, also troubled by the economic dislocations of the Industrial Revolution and empowered with scientific advances, such as the germ theory of disease, pressed for state-sponsored public health reforms.

World War II and the establishment of the United Nations (UN) are the watershed events in the evolution of the modern corpus of international human rights law and the current international human rights system. The UN embraced the recognition and protection of human rights as a core strategy for world peace. Since the UN Universal Declaration of Human Rights in 1948,<sup>3</sup> a substantial body of international law has developed recognizing basic human rights and their promotion and protection. In brief, there are two major sources of international human rights law that are relevant to the right to health: (1) international treaties of the UN and regional international organizations such as the Organization of American States, and (2) customary international law.

#### A. *International Treaties*

The 1948 UN Universal Declaration of Human Rights is not a treaty but a statement of policy and a call to action much like the Declaration of Independence. It affirmatively states a human right to health: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including . . . medical care . . . and the right to security in the event of . . . sickness, disability . . ."<sup>4</sup>

In the 1960s, the UN sponsored the development of two international covenants that articulate the human rights recognized in the UN Universal Declaration of Human Rights. These two covenants are the International Covenant on Civil and Political Rights (ICCPR)<sup>5</sup> and the International Covenant on Economic, Social and Cultural Rights (ICESCR).<sup>6</sup>

The International Covenant on Economic, Social and Cultural Rights (ICESCR)—the so-called Economic Covenant—is the most important in terms of the right to health. Article 12 of ICESCR states that the right to health includes "the enjoyment of the highest attainable standard of physical and mental health."<sup>7</sup> The relevant provisions of this covenant are presented in Figure 1.

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3. UN Universal Declaration of Human Rights, G.A. Res. 217A (III), art. 13.1, U.N. GAOR, 3d Sess., at 71, 74, U.N. Doc. A/810 (1948).

4. *Id.*

5. International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, at 49, U.N. Doc. A/6316 (1966).

6. International Covenant on Economic, Social and Cultural Rights, G.A. Res. 22001 (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316, 993 U.N.T.S. 3 (1966).

7. *Id.*

**Figure 1**  
**The International Covenant on Economic, Social and Cultural Rights (ICESCR)**  
**Article 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;
  - (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.

The UN Committee on Economic, Social and Cultural Rights has responsibility for the promotion, implementation and enforcement of this covenant. A human right to health is also recognized in numerous other international human rights authorities that establish prohibitions against government conduct that is detrimental to health. Such treaties include the International Convention on the Elimination of All Forms of Racial Discrimination of 1965,<sup>8</sup> the Convention on the Elimination of All Forms of Discrimination against Women of 1979,<sup>9</sup> and the Convention on the Rights of the Child of 1989.<sup>10</sup>

The UN also has established several international agencies to promote economic and social development world wide. The World Health Organization (WHO) has a legislative capacity to make international health regulations in addition to its health promotion functions. The WHO constitution states a right to the "highest attainable standard of health" and defines health broadly as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."<sup>11</sup>

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8. International Convention on the Elimination of All Forms of Racial Discrimination, Dec. 21, 1965, art. 5(d)(vii), G.A. Res. 2106 (XX), U.N. GAOR, 20th Sess., Supp. No. 14, at 47, U.N. Doc. A/6014 (1965), 660 U.N.T.S. 195, 222 (*entered into force* Jan. 4, 1969).

9. Convention on the Elimination of All Forms of Discrimination Against Women, Dec. 18, 1979, art. 12, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, U.N. Doc. A/34/36 (1980) (*entered into force* Sept. 3, 1981).

10. Convention on the Rights of the Child of 1989, Nov. 20, 1989, art. 24, G.A. Res. 44/25, U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc A/44/49 (1989) (*entered into force* Jan. 4, 1969).

11. Constitution of the World Health Organization, *opened for signatures* July 22, 1946, 62



In addition, regional international organizations have treaties and implementation bodies. The Inter-American system for the protection of human rights of the Organization of American States (OAS) is based on the OAS American Declaration of the Rights and Duties of Man<sup>12</sup> and the OAS American Convention on Human Rights,<sup>13</sup> among other instruments. Specifically, Article 11 of the American Declaration of the Rights and Duties of Man states “[e]very person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources.”<sup>14</sup> The more recent Protocol of San Salvador specifies a human right to health in its interpretation of the OAS Convention on Human Rights.<sup>15</sup> These provisions are presented in Figure 2.

**Figure 2**  
**Protocol of San Salvador**  
**Article 10**

1. Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being.
2. In order to ensure the exercise of the right to health, the States Parties agree to recognize health as a public good and, particularly, to adopt the following measures to ensure that right:
  - a. Primary health care, that is, essential health care made available to all individuals and families in the community;
  - b. Extension of the benefits of health services to all individuals subject to the State's jurisdiction;
  - c. Universal immunization against the principal infectious diseases;
  - d. Prevention and treatment of endemic, occupational and other diseases;
  - e. Education of the population on the prevention and treatment of health problems, and
  - f. Satisfaction of the health needs of the highest risk groups and of those whose poverty makes them the most vulnerable.

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Stat. 6279, 14 U.N.T.S. 185.

12. American Declaration of the Rights and Duties of Man, Mar. 30-May 2, 1948, O.A.S. res. XXX, adopted by the Ninth International Conference of American States, Bogota Columbia, OEA/Ser. L/V/II, 23 doc., 21 rev. 6 (1948), *reprinted in* ORGANIZATION OF AMERICAN STATES, BASIC DOCUMENTS PERTAINING TO HUMAN RIGHTS IN THE INTER-AMERICAN SYSTEM 17-24 (1988).

13. American Convention on Human Rights, *opened for signatures* Nov. 22, 1969, O.A.S. Official Records, OEA/Ser. K/XVI/II, doc. 65, rev. 1, corr. 2, 144 U.N.T.S. 123, 9 I.L.M. 673, 678 (1970), *reprinted in* ORGANIZATION OF AMERICAN STATES, *supra* note 13, at 25-54.

14. American Declaration of the Rights and Duties of Man, *supra* note 11, at art. 11.

15. Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, Nov. 14, 1988, O.A.S. T.S. 69 at art.10 (1988), *reprinted in* THE INTER-AMERICAN SYSTEM OF HUMAN RIGHTS 500 (David J. Harris & Stephen Livingstone eds., 1998).

The Pan-American Health Organization (PAHO), located within WHO, promotes health in the Americas and implementation of these OAS instruments that recognize an international human right to health.

Also of interest, the 1993 Vienna Declaration and Programme of Action emphasizes the fundamental inter-relatedness of political and civil human rights and economic social and cultural human rights.<sup>16</sup> The Vienna Declaration specifically provides:

All human rights are universal, indivisible and interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of States, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms.<sup>17</sup>

The Vienna Declaration has become a crucial principle in international human rights law recognizing the irreducible truth that all human rights must be recognized if specific human rights are to have concrete meaning. A look to the body of international treaties that comprise the corpus of human rights law at first glance seems promising. However, these treaties bind only those nations that ratify them. This situation is immediately disappointing with respect to the United States as the United States has not ratified many UN or OAS human rights treaties. Most importantly, the United States has signed but not ratified ICESCR and the two conventions on the rights of women and children. The Clinton Administration supported but did not achieve ratification. Also, when the United States has ratified a treaty, it has carefully limited its commitment through extensive reservations and generally assures that treaties are not self-executing under American law. At Figure 3 is a list of the major UN and AOS treaties establishing an international human right to health and the US commitment, or lack thereof, to these treaties.

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16. 1993 Vienna Declaration and Programme of Action, U.N. GAOR, World Conference on Human Rights, 78th Sess., 22d plen. mtg., part 1, art. 5, U.N. Doc. A/CONF 157/23 (1993).

17. *Id.*

<b>FIGURE 3</b>		
<b>SIGNATURE AND RATIFICATION OF MAJOR INTERNATIONAL HUMAN RIGHTS INSTRUMENTS BY THE UNITED STATES</b>		
<b>INSTRUMENT</b>	<b>SIGNATURE</b>	<b>RATIFICATION</b>
<b>UNITED NATIONS</b>		
UN Declaration of Human Rights (Not a Treaty)	Yes	N/A
Constitution of the World Health Organization	Yes	Yes
International Covenant for Civil and Political Rights (ICCPR)	Yes	Yes 6/8/92
The International Covenant for Economic, Social and Cultural Rights (ICESCR)	Yes 10/5/77	No
International Convention on the Elimination of All Forms of Racial Discrimination of 1965	Yes	Yes 10/21/94
Convention on the Elimination of All Forms of Discrimination against Women of 1979	Yes 7/17/80	No
Convention on the Rights of the Child of 1989	Yes 2/16/95	No
<b>ORGANIZATION OF AMERICAN STATES</b>		
American Declaration of the Rights and Duties of Man (Not a Treaty)	Yes	N/A
American Convention on Human Rights ("Pact of San Jose, Costa Rica") (1969)	Yes 6/01/77	No
Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights ("Protocol of San Salvador") (art. 10) (1988)	No	No

Why is the United States' commitment to international human rights treaties so mixed? One major reason is that international human rights treaties, unlike other types of international law, address internal matters of nations that fall within the realm of domestic policy. While the United States was actively involved in the development of international human rights instruments after



World War II, Senate ratification came slowly given concerns among Southern senators in the 1950s that ratification would incur international scrutiny of racial discrimination in the South. Also, the initial promise of the UN Declaration of Human Rights was subsumed by the Cold War politics that pitted Capitalism against Socialism.

The United States did not really embrace international human rights until the late 1970s when President Carter made human rights a cornerstone of American foreign policy. However, this period was brief. The Reagan-Bush administrations put other priorities over human rights promotion in their foreign policy. It is my hope that, with the end of the Cold War, the United States and other nations will take a new look at human rights generally and especially human rights of an economic nature such as the right to health.

### *B. Customary International Law*

Customary international law holds promise as an important source of international law with respect to human rights. International customary law is interesting for it can legally bind nations regardless of treaty ratification. Section 102 of the Restatement (Third) of Foreign Relations Law of the United States contains a definition of international customary law.<sup>18</sup> As Section 102 states: "Customary international law results from a general and consistent practice of states followed by them from a sense of legal obligation."<sup>19</sup> The two major elements of customary international law are state practice and *opinio juris*, a state's sense of legal obligation.

Customary international law also is promising when it comes to establishing a binding international human right to health in the nations of the world. Under the principles for the development of customary international law, widespread ratification of UN and regional treaties and other instruments recognizing international human rights can establish an international customary law of human rights. Specifically, treaties, declarations and other instruments become evidence of a general state practice in which states engage out of a sense of legal obligation. As evidence of general practice followed out of a sense of legal obligation, they establish the human rights obligations in the instruments as a customary international law. As international customary law, the obligations in the international human rights instruments then impose obligations on states, including the United States, that have not ratified the treaties. Thus, for example, the ICESCR is arguably customary international law due to its widespread acceptance internationally. As a consequence, it may be binding on all countries regardless of ratification.

Other law and practice in the United States and other nations provides evidence of custom regarding the international human right to health. Many nations, particularly Western democracies as well as many developing nations, establish an explicit right to health in their constitutions. Figure 4 presents the number of nations that have such provisions establishing a right to health in their

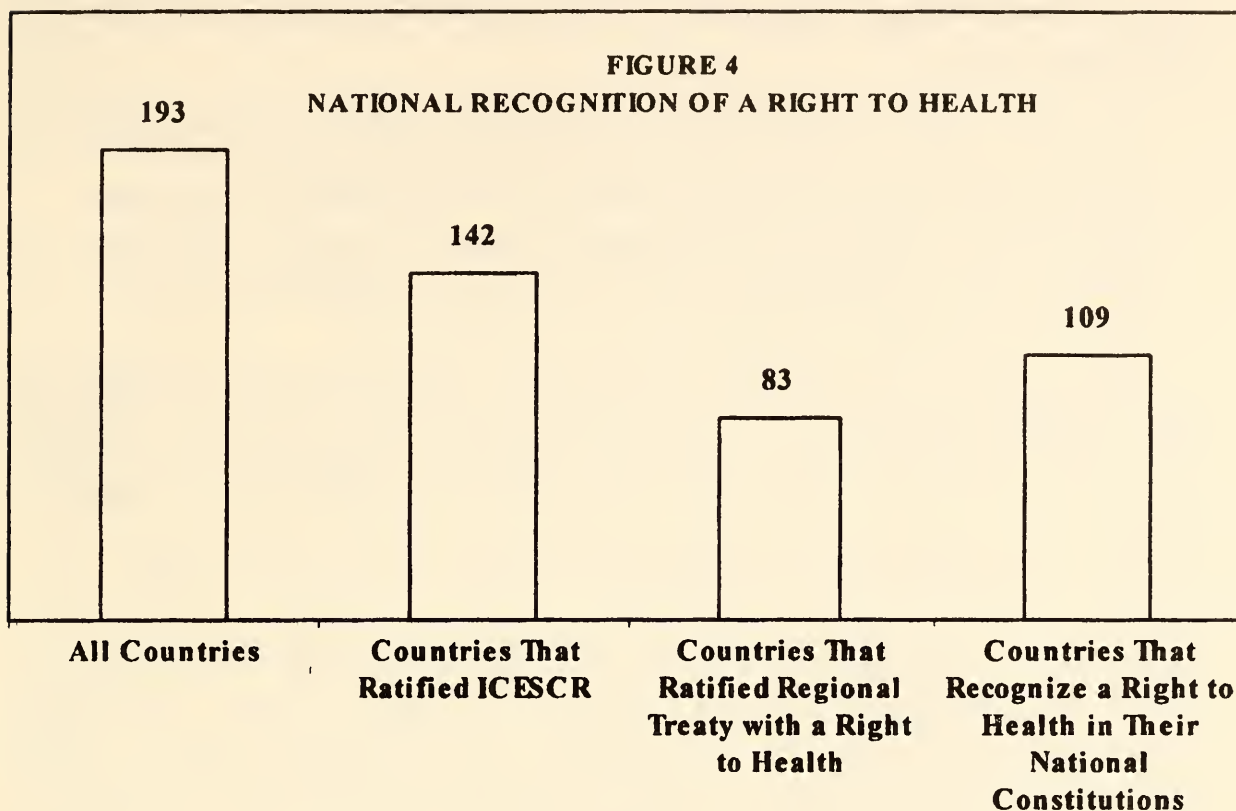
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18. See RESTATEMENT (THIRD) OF FOREIGN RELATIONS LAW § 102 (1987).

19. *Id.*



constitutions. Figure 4 also presents the number of nations that have signed UN or regional treaties and other instruments that recognize the human right to health.



With respect to the United States, the Federal Constitution permits Congress to provide for the general welfare.<sup>20</sup> However, the Federal Constitution, as interpreted by the Supreme Court, does not recognize a right to health care as a matter of constitutional law.<sup>21</sup> For example, in *Maher v. Roe*,<sup>22</sup> the Court stated that “[t]he Constitution imposes no obligation on the states to pay . . . any of the medical expenses of indigents.”<sup>23</sup>

Additionally, some constitutions of individual American states expressly recognize a right to health. For example, Alaska and Hawaii, the most recently admitted states, have provisions that either the legislature (Alaska) or the state (Hawaii) must provide for the promotion and protection of public health.<sup>24</sup> The Wyoming constitution contains a similar provision imposing the following duty on its legislature: “As the health and morality of the people are essential to their well-being, and to the peace and permanence of the state, it shall be the duty of

20. See U.S. CONST. art. 1, § 8, cl. 1.

21. BARRY R. FURROW, HEALTH LAW §10-1 (2d ed. 2000).

22. 432 U.S. 464 (1977).

23. *Id.* at 469.

24. See ALASKA CONST. art. VII, § 5; HAW. CONST. art. IX, § 1.

the legislature to protect and promote these vital interests . . .”<sup>25</sup> Similarly, South Carolina’s constitution designates health a matter of public concern: “The health . . . of the people of this State and the conservation of its natural resources are matters of public concern.”<sup>26</sup> Montana’s constitution is perhaps the most emphatic in providing a right to health as an affirmative matter in its section on inalienable rights:

All persons are born free and have certain inalienable rights. They include the right to a clean and healthful environment and the rights of pursuing life’s basic necessities, enjoying and defending their lives and liberties, acquiring, possessing and protecting property, and *seeking their safety, health and happiness in all lawful ways*. In enjoying these rights, all persons recognize corresponding responsibilities.<sup>27</sup>

Furthermore, many nations have statutorily-mandated health coverage and public health programs for all or part of their populations. For example, both the federal and state governments of the United States have always promoted public health measures and have provided some health coverage for vulnerable groups. Specifically, states pursuant to their police powers and the federal government through the constitutional mandate to promote the general welfare have sponsored public programs and regulatory measures to protect and promote public health.<sup>28</sup> Also, the federal government provides health insurance to the elderly and disabled through the Medicare program.<sup>29</sup> Further, the federal government and all states are joint partners in the Medicaid program which serves poor children and their mothers as well as the poor elderly and disabled.<sup>30</sup> This considerable, if incomplete, commitment of governments to the provision of health care services pursuant to statute provides additional evidence of general state practice supporting the international human right to health as a matter of international customary law.

However, recognition of an international right to health as a matter of international customary law clearly has some problems. There is a circularity in the rationale for international customary law that is problematic. The Restatement Reporter’s comments lay out some of the problems with customary international law as now defined:

Each element in attempted definitions has raised difficulties. There have been philosophical debates about the very basis of the definition: how can practice build law? Most troublesome conceptually has been the circularity in the suggestion that law is built by practice based on a sense of legal obligation: how, it is asked, can there be a sense of legal

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25. WYO. CONST. art. 7, § 20.

26. See S.C. CONST. art. XII, § 1.

27. MONT. CONST. art. II, § 3 (emphasis added).

28. See LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 25-59 (2000).

29. See 42 U.S.C. §§ 1395a-1395ggg (2000).

30. See *id.* at §§ 1396-1396v.



obligation before the law from which the legal obligation derives has matured?<sup>31</sup>

The reporter goes on to observe that “[s]uch conceptual difficulties, however, have not prevented acceptance of customary law essentially as here defined” and opines that “[p]erhaps the sense of legal obligation came originally from principles of natural law or common morality, often already reflected in principles of law common to national legal systems [and] practice built on that sense of obligation then matured into customary law.”<sup>32</sup>

Customary international law—particularly as it pertains to economic rights such as the right to health—is also problematic from another perspective. What kind of remedies attend the human right to health recognized under customary international law? Can an American citizen sue in an international court to enforce this right? If so, can an international court rule that the United States or its component states has some kind of obligation to provide the individual involved access to needed health care services? If not, what is the extent of the customary human right to health beyond a moral duty?

## II. IMPLEMENTING THE INTERNATIONAL RIGHT TO HEALTH

If there is a binding international human right to health, then how would it be defined and implemented? This is a challenge. In this effort, we should be imaginative. As lawyers, we tend to think of administrative regulation and enforcement as well as judicial recourse as the primary mechanisms for assuring the implementation of rights. However, these models may not be particularly appropriate or effective when we are talking about what, at least in the United States and many other nations, is essentially a right to health under international customary law.

Such legalistic visions of the right to health may also not be appropriate or effective as there is still some uncertainty about the content of the international human right to health. Indeed, getting a handle on the content of the right to health is a necessary first step to effective implementation. But this is no easy task. To have meaning, the content of the right to health must be essentially the same for all nations and people. Yet implementation is dependent on the resources, as well as cultures, of individual countries. How do we articulate the right to health in countries with vastly different economic resources and cultural traditions?

### A. *General Comment 14*

The UN Committee on International Economic, Social and Cultural Rights—the treaty body responsible for implementing and monitoring ICESCR—has published a General Comment 14 to ICESCR that outlines the content to the international right to health.<sup>33</sup> This General Comment is extensive

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31. RESTATEMENT (THIRD) OF FOREIGN RELATIONS LAW § 102, cmt. 2 (1986).

32. *Id.*

33. United Nations, Committee on Economic, Social and Cultural Rights, U.N. ESCOR, 22d

and quite specific and intended to apply to nations that have ratified the ICESCR. It addresses the content of the right to health and the implementation and enforcement of the right to health. It also provides remedies for individual parties who have been denied the human right to health.

General Comment 14 begins with some observations about the normative content of the right to health. Specifically, General Comment 14 states that “[t]he right to health is not to be understood as a right to be *healthy*” and that “[t]he right to health contains both freedoms and entitlements.”<sup>34</sup> The General Comment 14 specifies the freedoms and entitlements as follows:

The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.<sup>35</sup>

General Comment 14 then observes that the right to health extends

not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.<sup>36</sup>

These provisions of General Comment 14 indeed prescribe a broad and inclusive conception of the content of the human right to health.

General Comment 14 also provides that the health care system of a states party must have certain institutional characteristics to realize the right to health. These include the availability, accessibility, acceptability and quality of needed health care services and facilities. “Availability” means that the states party has sufficient facilities and services for the population given the country's state of development. Services include those that affect the underlying determinants of health, such as safe and potable drinking water. “Accessibility” to health care facilities and services include the four dimensions: non-discrimination, physical accessibility, economic accessibility (affordability), and information accessibility. “Acceptability” means that services and facilities must be respectful of medical ethics and culturally appropriate as well as being designed to respect confidentiality and improve the health status of those served. “Quality” means that services must also be scientifically and medically appropriate and of good quality.<sup>37</sup>

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Sess., *The Right to the Highest Attainable Standard of Health*, U.N. Doc. E/C, Dec. 4, 2000, ICESCR General Comment 14 (2000).

34. *Id.* (emphasis in original).

35. *Id.*

36. *Id.*

37. *See id.*



General Comment 14 imposes three types or levels of obligations: the obligations to *respect*, *protect* and *fulfill*. The obligation to *respect* requires states parties to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to *protect* requires states parties to take measures that prevent third parties from interfering with article 12 guarantees. The obligation to *fulfill* requires states parties to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.<sup>38</sup> General Comment 14 also reaffirms that several “core” obligations have been established in prior international human rights instruments: These core obligations, as well as additional obligations, are presented in Figure 5.

Figure 5

**GENERAL COMMENT 14  
OBLIGATIONS REGARDING THE HUMAN RIGHT TO HEALTH**

**Core Obligations Established in  
Prior International Human Rights Instruments:**

To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups:

To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;

To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;

To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;

To ensure equitable distribution of all health facilities, goods and services;

To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.

**Obligations of Comparable Priority:**

To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;

To provide immunization against the major infectious diseases occurring in the community;

To take measures to prevent, treat and control epidemic and endemic diseases;

To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;

To provide appropriate training for health personnel, including education on health and human rights.

38. *See id.*

General Comment 14 clearly addresses implementation. It imposes a duty on each states party "to take whatever steps are necessary to ensure that everyone has access to health facilities, goods and services so that they can enjoy, as soon as possible, the highest attainable standard of physical and mental health."<sup>39</sup> Implementation requires adoption of "a national strategy to ensure to all the enjoyment of the right to health, based on human rights principles which define the objectives of that strategy, and the formulation of policies and corresponding right to health indicators and benchmarks."<sup>40</sup> The national health strategy should also "identify the resources available to attain defined objectives, as well as the most cost-effective way of using those resources."<sup>41</sup> The national health strategy and plan of action should "be based on the principles of accountability, transparency and independence of the judiciary, since good governance is essential to the effective implementation of all human rights, including the realization of the right to health."<sup>42</sup>

General Comment 14 has extensive enforcement provisions and specifies violations of the right to health. The Comment explicitly provides that a states party which "is unwilling to use the maximum of its available resources for the realization of the right to health is in violation of its obligations under Article 12."<sup>43</sup> Further, if resource constraints make compliance impossible, the states party "has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above."<sup>44</sup>

General Comment 14 also specifies violations. For example, violations of the obligation to respect include "state actions, policies or laws that contravene the standards set out in Article 12 of the Covenant and are likely to result in bodily harm, unnecessary morbidity and preventable mortality."<sup>45</sup> Violations of the obligation to protect include "failure of a State to take all necessary measures to safeguard persons within their jurisdiction from infringements of the right to health by third parties."<sup>46</sup> Finally, violations of the obligation to fulfil include "failure of States parties to take all necessary steps to ensure the realization of the right to health."<sup>47</sup>

Finally, General Comment 14 accords remedies to individual parties. Specifically, any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels. All victims of such violations should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition. National

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39. *Id.*

40. *Id.*

41. *Id.*

42. *Id.*

43. *Id.*

44. *Id.*

45. *Id.*

46. *Id.*

47. *Id.*



ombudsmen, human rights commissions, consumer forums, patients' rights associations or similar institutions should address violations of the right to health.<sup>48</sup>

General Comment 14 represents a significant step in delineating the international human right to state parties to the ICESCR. Yet, despite General Comment's specificity, as well as flexibility, the issue of how General Comment 14 will be interpreted, implemented and enforced in states parties at different stages of economic development and with markedly different cultures and values will still be a challenge. In sum, the content of the international right to health remains a tough issue. Thus, we ought to think carefully about how it is implemented and, more particularly, how it is enforced.

### *B. Realistic Implementation and Enforcement*

When all is said and done, legal rights should be enforceable. Otherwise, we are back to where we began at the beginning of this paper. The human right to health is just a moral right after all. Realistically, implementation and enforcement of the international right to health is difficult particularly if predicated on customary international law. Implementation requires affirmative action on the part of government, and implicates intervention in the internal domestic affairs of nations. The United States and other nations would probably not tolerate excessive interference in their domestic affairs that are specified in General Comment 14 if they have not ratified ICSECR. Further, given the diverse cultures and economic levels of the nations of the world, it is hard to envision a mandate that would implement the right to health that would be appropriate to all nations.

But if the international right to health is to mean anything at all, it does seem appropriate to impose some implementation obligations on states and also require some type of regulation to assure implementation and enforcement. We must allow states considerable latitude to define strategies for implementation within their national economic, social and cultural circumstances. Universal coverage through prepaid managed care plans may make sense for the United States but is a ridiculous proposal for the Sudan. But if we allow such discretion, how do we not virtually vitiate the international right to health?

### *C. Proposed Approaches*

Given economic, social and cultural differences among the nations of the world, I think that we should take three major approaches. First, define universal outcome measures that measure compliance with the core state obligations of the human right to health. Second, establish systematic reporting to responsible international bodies to monitor progress on implementation and compliance with international human rights obligations. Third, highlight civil rights violations, such as discrimination against protected groups, that inhibit access to health care services.

1. *Use of Outcome Measures.*—The first approach, defining universal

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48. *See id.*

outcome measures for measuring the implementation of the human right to health is essential. Outcome measures would also indicate where countries need to concentrate efforts to meet their obligations under the international human right to health. They also assist in establishing concrete goals for human rights implementation.

The UN and the WHO already appreciate the possibilities of reported data on outcome measures in monitoring compliance of states with international human rights obligations. In its *Human Development Report 2000*,<sup>49</sup> the UN expressly recognizes a link between human rights and human development as well as the use of comparative data to measure compliance with international human rights obligations. Specifically, the UN acknowledges the potential use of such statistical indicators in human rights enforcement:

Statistical indicators are a powerful tool in the struggle for human rights. They make it possible for people and organizations—from grassroots activists and civil society to governments and the United Nations—to identify important actors and hold them accountable for their actions. This is why developing and using indicators for human rights has become a cutting-edge area of advocacy.<sup>50</sup>

In this report, the United Nations has created four major indicators of economic development of use in measuring progress toward the achievement of economic human right. These are: (1) Human Development Index; (2) Gender Related Development Index; (3) Gender Empowerment Measure; and (4) Human Poverty Index. Further, in its *World Health Report 2000*, the WHO reports health system attainment and performance measures for member states. These measures are presented in Figure 6.

**Figure 6**

**World Health Report 2000  
Health System Attainment and Performance Measures**

Health system attainment and performance in all Member States, ranked by eight measures

Basic indicators for all Member States

Deaths by cause, sex and mortality stratum in WHO Regions

Burden of disease in disability-adjusted life years (DALYs) by cause, sex and mortality stratum in WHO Regions

Health attainment, level and distribution in all Member States

Responsiveness of health systems, level and distribution in all Member States

Fairness of financial contribution to health systems in all Member States

49. UNITED NATIONS, HUMAN DEVELOPMENT REPORT 2000 (2000).

50. *Id.* at 89.



2. *Establish a Comparative Reporting System.*—If a country meets these universal outcome measures specified in a systematic reporting system, responsible international bodies, as well as domestic constituencies, will assume that implementation and compliance have occurred. This approach mitigates the need for international bodies to delve deeply into the internal affairs of nations to assure implementation and compliance. The importance of comparative reporting and publication of comparative statistics can do much to advance the implementation of the human right to health, particularly with respect to state obligations to take affirmative measure to promote public health or expand health coverage.

The WHO has begun reporting country health statistics on a comparative basis. Specifically, in *World Health Report 2000*, WHO published its first comparative analysis of the world's health systems. Using five performance indicators to measure health systems in 191 member states, WHO found that France provides the best overall health care followed among major countries by Italy, Spain, Oman, Austria and Japan.<sup>51</sup>

Indianapolis, Indiana, provides an nice exemplary case of the potential role and impact of reporting of health system performance outcome measures in correcting health system deficiencies and promoting health reform. In 1984, 1985 and 1987, Indianapolis had the highest black infant mortality rate of any city in the United States—higher than Detroit, Washington, DC, and New York. The Indianapolis infant mortality rate for blacks was about twenty-five in 1000. Countries with lower rates included United Arab Emirates, Soviet Union, Argentina, China, Trinidad, Sri Lanka, Jamaica, Cuba, Korea, and Singapore. The existence and publication of this statistic embarrassed civic and political leaders. Consequently, they adopted strategies on their own to address this problem with some success in a collaborative initiative called the Indianapolis Campaign for Healthy Babies.<sup>52</sup> In sum, the comparative statistics on infant mortality spurred government and private organizations to mobilize and address this public health problem.

3. *Highlight Civil Rights Violations.*—Highlighting civil rights violations, such as discrimination against protected groups with respect to health care services, can do much to promote the international human right to health generally. For example, elimination of discrimination against women, minorities and other disadvantaged groups in the provision of appropriate health care services can do much to promote the right to health generally. This approach reinforces the admonition of the 1993 Vienna Declaration quoted above that all human rights are highly inter-related.<sup>53</sup>

An example of the importance of recognizing the distinctions between the different types of rights that are subsumed in the larger right to health is the case of AIDS. According women equal status in marriage and divorce and recognizing fully their civil and political rights does much to empower women

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51. Press Release, World Health Organization, *World Health Report 2000* (Feb. 21, 2001), available at [http://www.who.int/whr/2000/en/press\\_release.htm](http://www.who.int/whr/2000/en/press_release.htm).

52. See MARION COUNTY HEALTH DEP'T, *HEALTHY BABIES IN THE NEW MILLENNIUM* (1999).

53. See *supra* note 16 and accompanying text.

in rejecting unwanted sexual relations with HIV-infected partners.<sup>54</sup> Clearly, recognition and enforcement of civil rights for women would do much to prevent HIV infection and associated AIDS.

### III. WHAT DOES THE HUMAN RIGHT TO HEALTH MEAN TO THE UNITED STATES AND THE WORLD?

Finally, what difference would it make to the nations of the world if there were a legal mandate for a human right to health? Such a legal mandate would play a tremendous role in making the promotion of public health and the expansion of health coverage a priority in all nations. Such recognition would encourage nations to promote health care programs as a priority. Such promotion in recent years has been exceedingly difficult due to the supervision of the economies of debtor nations by the International Monetary Fund with its neo-conservative economic policies for debtor nations.<sup>55</sup>

Specifically, in the poor debtor nations of the world, recognition of a human right to health could shape lending policies of the International Monetary Fund and the World Bank in several ways. It could bolster efforts to protect infrastructure for the provision of health care services in a country by recognizing the importance of the right to health in the imposed economic development policies associated with international loans and economic assistance. Also, this right could end the disruptive practice of requiring user fees for the use of publicly funded clinics and other health care services—a widespread practice under neo-conservative policies of these lending bodies that has had a detrimental impact on health in poor debtor nations.

But what really does international human rights law have to contribute to a country as advanced and civilized as the United States? Don't we have the best health care system in the world? Compared to other nations and especially western democracies, the U.S. record with respect to access to health care and public health services is not strong. Indeed, the WHO ranked the performance of the U.S. health care system thirty-seventh among all nations due to disparities by race and income.<sup>56</sup>

When compared to its peers, the United States compares quite unfavorably despite the fact it expends more per capita on health care than any other country. The United States ranked eighteenth in female life expectancy and twenty-second in male life expectancy.<sup>57</sup> The infant mortality rate in the United States was higher than all ODEC countries except Hungary, Korea, Mexico, Poland and Turkey.<sup>58</sup>

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54. See GOSTIN & LAZZARINI, *supra* note 1, at 46.

55. WALDEN BELLO ET AL., DARK VICTORY: THE UNITED STATES AND GLOBAL POVERTY (1999); MICHAEL CHOSSUDOVSKY, THE GLOBALIZATION OF POVERTY: IMPACTS OF IMF AND WORLD BANK REFORMS (2000).

56. See *supra* note 51.

57. See Gerard F. Anderson & Jean-Pierre Poullier, *Health Spending, Access, and Outcomes: Trends in Industrialized Countries*, HEALTH AFF., May-June 1999, at 178.

58. See *id.* at 190.



Additionally, the U.S. compares very unfavorably on health coverage. Over 42.5 million Americans (15.5%) have no health insurance coverage—a major increase since 1990s despite the strong performance of the American economy since the recession of the early 1990s.<sup>59</sup> Of these, 32.4% of the poor or 10.4 million people are without coverage.<sup>60</sup> The United States is one of four ODEC countries in which publically-sponsored coverage is not at last ninety-nine percent.<sup>61</sup> With 33.3% public coverage, the United States stands behind Turkey, Mexico and the Netherlands.<sup>62</sup> While clearly there may be differences in the quality of public coverage among ODEC countries, nearly every ODEC country has made a greater commitment to health coverage than the United States.

### CONCLUSION

I have only outlined a few ideas about the international human right to health and what it could mean for our world and nation. I do think that the international human rights to health—as established under international customary law—arguably impose greater obligations on the United States and other nations with respect to health than we currently appreciate or recognize.

I would like to close with one question: Could it be that our obligations under international human rights law mean that we should spend some of our surplus on assuring health coverage for all Americans? If we took the average annual per capita expenditure for Medicaid eligible in 1995—a mere \$3700—we could cover the 10.4 million poor currently without coverage for about \$38.5 billion per year.<sup>63</sup> Would that make such a dent in the surplus?

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59. See U.S. CENSUS BUREAU, CURRENT POPULATION REPORTS, HEALTH INSURANCE COVERAGE: 1999, at 2 (2000).

60. See *id.*

61. See Anderson & Poullier, *supra* note 57, at 181.

62. See *id.*

63. Katharine Levit et al., *Health Spending in 1998: Signals of Change*, 19 HEALTH AFF., Mar-Apr. 2000, at 124, 125.

