Introduction

We hear of human suffering everyday through various sources - when we turn on the television, read the newspapers and magazines, or surf the internet. But beyond being a poignant spectacle, suffering is an actual manifestation of the interplay of real factors, among them the issue of health. Apart from death, the other profound way of suffering is ill health, which damages the lives of those still living. Thus, global health is worth highlighting as one of the foremost challenges in today’s world.

Since the twentieth century, there have been momentous advancement in health, such as in life expectancy and mortality rates, and medical progress that introduced hundreds of safe and effective medicines to cure infectious diseases. However, this does not mean the end of any possible health threats and efforts are still needed to further combat global health concerns. Indeed, diseases that were overcome in the developed nations are still gripping developing and poverty-stricken countries, and there is still a long way to go before the developing world can reach the same level in population health as the more developed countries. For instance, chronic disease is responsible for 60% of deaths world-wide (80% of which occur in low and middle income countries),\(^1\) infectious diseases such as tuberculosis kills two million people every year (more than 90% of whom live in developing countries) and malaria continues to be a primary killer of children under five and a key contributor to adult morbidity in sub-Saharan Africa (with more than 300 million cases and more than one million deaths each year).\(^2\) The HIV/AIDS pandemic is one of the most urgent threats to global public health and in


2007, it was estimated that 33.2 million people world-wide are living with HIV.\(^3\)

Growing inequalities and disparities of living standards (and health) between the world’s richest and poorest are increasing concerns as well.\(^4\)

Given the centrality of health as a vital feature of the human condition, health has been recognized as a human right in numerous international documents\(^5\) and every country in the world is a party to at least one human rights treaty that deals with health-related rights. Although the terminology of the right to health is commonly employed in national and international human rights dialogue, still, the right to health (as part of economic, social and cultural rights) is hardly ever put on the same platform of importance as civil and political rights. The question this thesis embarks to explore is: are we moving towards a universal recognition of the human right to health; and accordingly, what does a right to health really entail under current international law; and how is the development of this right in light of the all-encompassing phenomenon of globalization?

In this introductory chapter, an outline of the structure of the rest of the thesis will be set out. Following that, there will be a section discussing why the ‘right to health’ is chosen as the more appropriate terminology in the discourse of the present thesis. Finally, the development of health as an international human right will also be discussed as this is vital to set the scene for later chapters in answering the main questions set out above.

1. Structure of the Thesis

The present thesis essentially concentrates on health as a human right. The objectives of this thesis are three-folds: firstly, to clarify the content and significance of the human

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\(^4\) See section 2 of Chapter Three pp. 117 – 122.

\(^5\) See section 3 of Chapter One pp. 31 – 39.
right to health; secondly, to explore recent developments of this human right; and thirdly, to recognize that in reality, implementation of the human right to health is much more complex and it goes beyond purely legal and theoretical dialogues, bearing in mind the numerous forces of globalization. With these objectives in mind, this study considers the three main questions set out in the previous section.

Chapter One initiates the process of clarifying and explaining the human right to health, which sets the necessary platform for the exploration of the relationship between health and human rights in subsequent chapters. Here, the embodiment of the right to health under international human rights law and in relevant treaty provisions is examined. Having looked at the enshrinement of the right to health, the chapter addresses an important, much-debated question – what does the term ‘health’ mean? Various definitions of health are explored, however it is also discussed whether a definition of health is really necessary. The vagueness and difficulty of defining certain words are issues commonly found within the framework of international law, for example trying to define the meaning of ‘life’. Another example is the Convention on the Rights of the Child. Countries cannot agree on what is meant by a child or, for instance, on the minimum age to join the army. Thus, the contents of the right to health are explored to provide a better framework for understanding what this human right entails under international law, culminating in a dialogue discussing the question as to whether or not health can be a compelling and applicable human right.

Chapter Two continues the discussion by studying the character and terms of the principle of ‘progressive realization’ enshrined in the International Covenant of

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Economic, Social and Cultural Rights (ICESCR)\(^7\) and the implications for States Parties. This chapter also explores the obligations and responsibilities of States Parties arising from their commitments under international human rights law to the human right to health. Besides, the monitoring systems of the right are briefly examined. The understanding of health as a human right and whether there is universal awareness or recognition of health as a human right is not complete without discussing the case law concerning the role of the right to health, especially in the context of the developing countries. This thesis acknowledges that there is potential case law relevant to the issue of health and human rights in the developed countries as well. However, it is not within the scope of this thesis to do a case law comparison between developed and developing countries. Besides, examples and further court cases highlighted throughout Chapters Three and Four essentially focus on the developing countries. Hence this thesis will concentrate mainly on the developing world.

In Chapter Three, the complexity of implementing the right to health in light of globalization is discussed. It basically highlights the growing disparities and chasms between the rich and the poor of world’s society and how globalization exacerbates ill health and accordingly affects the right to health of the people. In discussing the causal pathways between globalization and the human right to health, four main determinants are looked at: institutional, economic, environmental and social-cultural. It is noted that special focus is given to the institutional and economic determinants as they best depict the complexities of the system and their interconnectivity with human health. Besides,

these two determinants can also be linked to the issue of access to medicines addressed in Chapter Four.

Most human rights discussions have a tendency to be disproportionately legal and theoretical. While there is nothing wrong with the previous discourse on human rights, it is important to note that the dynamics of the world are constantly changing, and as Farmer puts it,

“…international institutions and transnational corporations now dwarf the dimensions of most states, the former institutions – and the small number of powerful states that control them – come to hold unfettered sway over the lives of millions… Only through careful analysis of growing transnational inequalities will we understand the complex social processes that structure not only growing disparities of risk but also what stands between us and a future in which social and economic rights are guaranteed by states or other polities.”

By discussing health in light of globalization, the human rights dialogues are transformed in significant and under-explored manners. Globalization is used to provide a reality platform to illustrate the daily struggle for social and economic rights (more specifically the human right to health). This is rather poignant when one considers the suffering that is abundant in the developing world. This thesis pays special attention to the plight of the developing countries, and in a way serves as an aide memoire that those who are usually at the mercy of human rights violations are the sick and the poor.

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Finally, a major theme running through Chapter Four is the issue of access to medicines, an imperative aspect of the right to health, in global health and its significance. As part of the continuation of the discussion on the globalization perspective of health and human rights, the Trade Related Intellectual Property Rights Agreement (TRIPS) and its implications will be explored. This chapter will also look into the significance of medicine prices and the roles of the major players or main providers of medicines in the world – both the corporate pharmaceutical companies as well as the generic drugs industries. The legal developments in the issues of intellectual property and access to medicines and health are also focal points of discussion.

2. The Right to Health: Terminology

There is much confusion as to the appropriate terminology to be used in the framework study of health and human rights. Different terminologies are used and the health and human rights law literature draws on various terms, ranging from the ‘right to health’ to ‘right to health care’ and to a lesser extent ‘right to health protection’. For the purpose of this thesis, the ‘right to health’ will be adopted. However, before delving into the reasons behind the selection of this terminology, the ‘right to health protection’ and the ‘right to health care’ will be highlighted first.

It is arguable that the ‘right to health protection’ may have similar scope as the right to health.9 Annus and Nõmper, who used this term to discuss the Estonian Constitution, also mentioned that the ‘right to health protection’ is tightly connected to many other rights, such as the right to food, shelter, healthy environment and access to health information.10

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9 Article 11 of the European Social Charter mentions the “right to protection of health”, see Chapter One.
However, to avoid the possibility of any confusion arising from the meaning of the term ‘protection’ or from a restrictive interpretation thereof, the term ‘right to health protection’ is foregone in the present thesis. Under international human rights law, the obligation to respect, protect and fulfill rights arises with regards to every specific human right; and governments must fulfill the range of obligations in relation to every human rights document ratified. Within this context, a specific meaning is granted to the term “to protect”, which means that the State has to take measures to prevent violations of this right by non-state actors and to offer accessible redress to the people in the event of any such violation. Considering the specific meaning of the term “protect” in this context, it is a better option not to use the ‘right to protection’ in a general sense, but to opt for the ‘right to health’ instead.

On the other hand, there are those who argued that opting for the term ‘right to health care’ is much more realistic. For example, Abbing claims that

“Health care can be at the disposal of man as far as it is realistic, which implies that the undertakings should be within the normal possibilities. A right to health care – other than a ‘right to health’- can be legally invoked by man: there is a legal duty to provide such care.”

The term ‘right to health care’ is much more specific and is usually taken to mean the provision of medical services. Thus, if the discussion is about national health care priorities setting or health care budget or expenditure, the ‘right to health care’ will be

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11 See Chapter One, Section 1.
12 See Chapter One, in which governmental obligations for health under international human right law is discussed in more detail with regards the right to health.
much more useful in that context. Indeed, the term ‘right to health’ has been criticized for conveying “an absurdity” as it suggests that people can claim a right to “perfect health”, which is something that cannot be guaranteed. As Häyry and Häyry state:

“Health is obviously some kind of state or condition, physical, psychological or social, whereas health care consists of services aimed at maintaining or regaining health … If health rather than health care is considered to be the thing all human beings have a right to, then the definition of health should be tailored accordingly. Inborn deficiencies and diseases could not in this case be seriously considered as elements of ‘unhealthiness’, since it would be hard to see for whom the possible right would guarantee a legitimate and meaningful claim. Would the alleged right imply that God or Nature owe us a duty as regards our health and well-being? … the interpretation that there is a right to health care rather than to health has the advantage over the first suggestion that it does not presuppose any specific definition of the concept of ‘health’…”

Nonetheless it should be noted that the right to health is not a right to be healthy, nor does it mean that everything that some people may perceive as medical services should be provided on demand. The term ‘right to health’ is chosen because of the reasons to be mentioned later and that it is important not only to recognize a ‘right to health care’, but also to recognize the complex underlying determinants to health in this global society.

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In the present thesis, the term ‘right to health’ will be used and the reasons justifying the use of this language will be looked at. As Leary puts it, “The precise terminology ‘right to health’, without further explanation, is not used in most provisions of treaties relating to health”. Even so, this terminology is best in line with the character of pertinent international human rights documents, and currently serves as a shorthand expression to the more detailed language contained in human right treaties and to fundamental human rights and health principle. To illustrate, both the language of the WHO’s Constitution and Article 12(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) recognizes “the right to the enjoyment of the highest attainable standard of [physical and mental] health”. As will be shown in Chapter One, other human rights instruments use terms closely analogous to this as well. Hence, it seems more suitable to truncate the term ‘right to the highest attainable standard of health’ to a ‘right to health’ than to other terminologies such as a ‘right to health care’.

The term ‘right to health’ is more commonly used at the international level, be it by international organizations such as the United Nations, human rights organs or legal scholars in this field. Leary quoted a few examples which evidenced extensive use of the ‘right to health’ in the human rights context. For instance, as far back as 1978, a multi-disciplinary workshop on “The Right to Health as a Human Right” was organized

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18 Ibid.
by the Hague Academy of International Law and the United Nations University. In a paper submitted by the United Nations Division of Human Rights entitled “The Right to Health”, Theo Van Boven used the term ‘right to health’ to refer to provisions implementing the standards and policies of health and human rights found in international instruments. Accordingly, he wrote:

“Three aspects of the right to health have been enshrined in the international instruments on human rights: the declaration of the right to health as a basic right; the prescription of standards aimed at meeting the health needs of specific groups of persons, and the prescription of ways and means for implementing the right to health.”

Another example is when the Committee on Economic, Social and Cultural Rights, which monitors the application of the ICESCR, held a “Day of General Discussion on the Right to Health” on 6 December 1993. The WHO also uses the term in many of its publications, for instance, the title of their fact sheet on health and human rights is entitled “The Right to Health”. Hence, it appears that using the term ‘right to health’ as a form of shorthand expression to refer to a much broader and complex picture is common in human rights dialogue; and as this thesis aims to be relevant in the international context, thus, it is more suitable for the ‘right to health’ to be used in this discussion.

Another reason to choose the term ‘right to health’ is because it encompasses a wider range of health-related issues. The history of public health has demonstrated that besides adequate provisions of health care facilities, the improvements of other factors such as

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sanitation, proper living conditions, safe drinking water and other environmental and occupational conditions, are interconnected to improve people’s health and lives. As mentioned before, the ‘right to health care’ does not cover as many perspectives as the ‘right to health’, and may be considered to be part of the ‘right to health’. It has been argued that in a very poor country, emphasis on a ‘right to health care’ positively undermines the broader right to health.\textsuperscript{24} In certain surroundings, establishing an infrastructure capable of delivering medical and nursing services is less cost-effective in promoting health than more basic measures such as the provision of sanitation and clean water.\textsuperscript{25} The objective of this thesis is to deal with the right to health of people especially in light of globalization and what it entails for the public health; thus, should the term ‘right to health care’ be used, it would mean a restrictive understanding of the right to health at the international level.

3. History of the Development of Health as an International Human Right

A recount of the history of international action on health is necessary to show how the stones for the recognition of health as a human right, both nationally and internationally, were laid.

Epidemics and diseases have been evolving continuously throughout mankind’s history. For thousands of years, epidemics were viewed mainly as divine judgements on the wickedness of mankind, and it was believed that these punishments were to be avoided by sacrifices and appeasing the wrathful gods.\textsuperscript{26} Nonetheless, community health activities in the earlier civilizations were evidenced by the construction of water supply, sewage

\textsuperscript{25} \textit{Ibid}.
systems and baths in ancient Egypt, India, in the Cretan-Mycenean culture and by the Incas.\textsuperscript{27} The Middle Ages was the period when many cities in Europe, especially through guilds, actively took part in founding hospitals and other institutions to provide medical care and social assistance.\textsuperscript{28}

Furthermore, international trade routes developed as a result of the availability of surplus grain, animals, and manufactured goods, connecting populations over vast geographical lands. While this further fostered worldwide trade and increased prosperity, it was also an avenue for the spread of infectious diseases. The opening of the Straits of Gibraltar to Christian shipping by the Genoese in 1291 and the development of trade routes across the Eurasian steppe by the Mongols created the conditions by which plague could spread throughout Europe after 1346.\textsuperscript{29}

The conquest of the Americas at the hands of the Spanish \textit{conquistadores} brought further repercussions in the spread of diseases. The Native American population became exposed to common diseases of the Old World – smallpox, measles, mumps, chickenpox and scarlet fever; and, the vulnerability of the native populations, who used to live in isolation from the rest of the world, provided a chance for pandemics of these diseases to decimate Caribbean Indians and visit populations in Peru and urbanized societies in Mexico with heavy mortality and morbidity burdens.\textsuperscript{30} Consequently, the Europeans began to replace their lost labour power with slaves from West Africa, who brought falciparum malaria to

\textsuperscript{27} \textit{Ibid}, 1-3.
the Americas, and the water casks on the slave ships brought the mosquito that carried yellow fever.\textsuperscript{31} On the other hand, the Europeans also encountered different diseases in the areas they colonized; for instance, when they attempted to settle or organized expeditions to areas where yellow fever and malaria were prevalent, the European mortality rates were very high.\textsuperscript{32} According to Aginam, “…this disease exchange propelled the transnationalisation of disease between the Old and New Worlds, reshaped the contours of colonialism and made disease a visible component of the entire colonial architecture.”\textsuperscript{33}

Since then, the spread of pathogens no longer depends on the speed of a caravan or long sea voyages - transatlantic flights allow tourists, business people, political refugees, migrant workers, and soldiers to travel around the world in hours, with the potential for carrying new diseases with them; and container ships transporting goods from around the world can import everything from trucks to rats and mosquitoes.\textsuperscript{34}

As disease pathogens ignored geo-political boundaries and spread across the world, the practice of quarantine was introduced and enforced. It was initially a successful means of control, but by the mid-nineteenth century, it confronted two major challenges. The first was the increasing volume, especially the speed of trade due to the introduction of railways and the steamship; and delays due to quarantine were increasingly costly and

\textsuperscript{31} Ibid.


The second was the appearance of cholera in Europe, a disease beyond the control of the existing arrangement of quarantine.

It was around this time that the initial steps towards an international health organization were taken, starting with the first International Sanitary Conference, which convened in Paris on 23 July 1851. From 1851 to 1887, ten International Sanitary Conferences were held but yielded few notable accomplishments. While this was partly due to a lack of understanding of the etiology of cholera, more significantly was the inability of the European powers to define their political interests coherently with those of their neighbours. Although delegates supported the proposal that cholera be subjected to quarantine regulations, their governments were unable to ratify this decision; and it was not until many such conferences later that governments, meeting in Venice in 1892, were able to agree to impose quarantine on ships that actually had cases of cholera on board. Indeed, the main purpose of the conference was not about improving global health, but rather to protect national interests politically and commercially, in the wake of exotic diseases such as cholera and yellow fever which could obstruct international trade.

Initially, to limit the spread of cholera, ships were quarantined at different ports for months at a time. However, as Siddiqi puts it,

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36 Paris (1859), Constantinople (1866), Vienna (1874), Washington (1881), Rome (1885), Venice (1892), Dresden (1893), Paris (1894), Venice (1897), and Paris (1903). To read more about these conferences, refer to Siddiqi (1995) 15 - 18.


“Arbitrary and unequal quarantine regulations … created great burdens on the international trade of chiefly maritime nations such as Britain and France, whose fear of economic collapse overwhelmed their dread of imported disease and led them to support some [form] of international action to relieve shipping from the shackles of quarantine regulations.”

The eleventh International Sanitary Conference in 1903 was significant because agreement was reached to establish a permanent international health office. Hence, the Office International d’Hygiène Publique (OIHP) was created in Paris to consolidate epidemiological information and to oversee international quarantine arrangements. By this time, not only were the etiological causes and means of transmissions of most infectious diseases discovered (as exemplified by Louis Pasteur's proof of the germ theory of disease; Robert Koch's discovery of the tubercle bacillus; and Walter Reed's revelation of the role of the mosquito in transmitting yellow fever), success was also achieved in the discovery of vaccines. This paved the way for the establishment of public health administration, based on scientific understanding of the elements involved in the spread of communicable diseases.

The limited staff and funding of the OIHP was insufficient to combat growing global health issues. Thus, the League of Nations subsequently established a new health organization to advise the League on health matters; to encourage international health cooperation; to simplify and hasten the exchange of epidemiological information between states; and to co-operate with the League Red Cross Societies and the International

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Labour Office. Although this health organization was short-lived following the termination of the League of Nations, their functions were broader than the OIHP, and set the precedent for the wide-ranging role of the World Health Organization (WHO).

In 1945, when diplomats met in San Francisco to form the United Nations, the setting up of a global health organization was discussed. They also highlighted the need of international law to continue to play a vital role in international health activities. Consequently, the WHO was born when sixty-one States signed the Constitution of the WHO on the 22 July 1946.

As the basic charter of the Organization, the Constitution sets forth its overall objective, lists its functions, establishes its central and regional structure, defines its legal status, and provides for co-operative relationships between it, the United Nations and other organizations, both governmental and private, in the area of health. Nine basic principles which are considered to be essential to the “happiness, harmonious relations and security of all peoples” are listed in the preamble of the Constitution; and a definition of health is provided. While not negatively construed as the absence of disease of infirmity, it was positively and broadly defined as “a state of complete physical, mental and social well-being”, which should be one of the basic rights of “every human being without distinction of race, religion, political belief, economic or social condition.” Within this context, international co-operation in health issues was held to

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46 Ibid.
include the improvement of national health in all countries, the dissemination of medical, psychological, and related knowledge throughout the world, and the development of an informed public opinion on health tribulations.\textsuperscript{47} Compared with the health organization of the League of the Nations, the WHO differs in terms of its establishment of universal membership and decentralization. What is of foremost significance is that the WHO is the first truly universal organization in the history of international co-operation in health, where almost all the world's states are members.\textsuperscript{48} As will be further looked at in Chapter One, the text of the Constitution played a role in inspiring the definition of a right to health in numerous international human rights treaties and documents.

Thus, the overall picture is as such - the early modern viewpoint of mercantilism focused on the need to measure the strength of the state by assessing levels of health; and as the modern, centralized states began to emerge from the late sixteenth century, early ideas of national health began to develop.\textsuperscript{49} Eventually, the understanding that the State is responsible for the health of the public gained ground, which led to the adoption of suitable health measures and legislations, and, further paving the way for more co-ordinated action in the international health setting. This will be discussed in more details in the following chapter.


\textsuperscript{48}  As of 2008, the WHO has 193 Member States. A complete list of countries can be found at \url{http://www.who.int/countries/en/}, accessed 3 November 2008.

4. Concluding Summary:

This introductory chapter explained why the ‘right to health’ is chosen as the terminology to be used in this thesis and also explored the development of health as an international human right. Having discussed those issues, the following chapters will consider the main question of this thesis: are we moving towards a universal recognition of the human right to health; and accordingly, what does a right to health really entail under current international law; and how is the development of this right in light of the all-encompassing phenomenon of globalization?
Chapter One: Health in a Human Rights Context

Introduction:

A right to health is one of the many economic, social and cultural rights, which together constitute the rapidly developing field of international human rights law. While campaigners, non-governmental organizations (NGOs) as well as academics have gained huge momentum in advancing a human rights approach to health and in health and human rights in general, the right to health is perhaps arguably one the most nebulous human rights. This chapter discusses the evolution of the idea of universal human rights. This chapter demonstrates the way in which the human right to health is enshrined in international human rights law and sets out relevant treaty provisions from a wide range of backgrounds (for example, regional and domestic settings) to show that the right to health, in the various manners it is phrased, is recognized worldwide. As far as sources are available, the travaux préparatoires of the treaties will be discussed.

The chapter examines the term ‘health’ in the context of a human right to health - bearing in mind that ‘health’ is a highly subjective matter. The parameters of this human right are also discussed. Finally, the debate as to whether or not health can form the basis of a human right is analysed. It should be noted that this question is too complicated to be answered simply, so the underlying theme of Chapters One and Two is to discuss this question by looking at specific aspects of the human right to health. In this chapter, the discussion focuses on the struggle between the liberal approach and the basic rights approach.
1. The Idea of Universal Human Rights

“The [expression] human rights indicate both their nature and their source: they are the rights that one has simply because one is human… human rights are held equally by all. [Because] being human cannot be renounced, lost or forfeited, human rights are inalienable… In practice not all people enjoy all their human rights, let alone enjoy them equally. Nonetheless, all human beings have the same human rights and hold them equally and inalienably.”

The modern notion of human rights is vibrant, promising, ambitious and complex. Today, they play a visible and important role in the conduct of international relations, affecting governments and individuals throughout the world. Thoughtful and insightful visionaries in many different times and places have imagined a world in which all people have responsibilities to those who possesses certain natural and inalienable rights, simply by virtue of being human. Based on this premise, a world without borders or other distinctions that divide people from one another, and, in which we are all entitled to receive equal treatment without any discrimination on the basis of gender, race, caste or class, religion, political belief, ethnicity or nationality, was imagined.

This chapter considers how the right to health is enshrined in international law. A brief introduction of the semantics of rights will help clarify the legal nature of human rights. In English, the word “rights” conjures up two meanings – moral on the one side; and legal or political on the other. In the moral sense, right refers to what is ‘right’ to do from...
a moral perspective, whereas in the legal sense, a right-holder can compel the duty-bearer to honour that right by calling on the courts to compel respect for the right. For example, not telling a lie to person A is morally right on the part of person B (telling a lie would be going against one’s sense of rightness); whereas a person’s right to vote is a human right protected and enforced by laws and a denial of that right creates a locus standi for the person to seek redress. Marks seeks to clarify the differences between “human rights” and “rights” by noting that,

“…in ethics a right refers to any entitlement, the moral validity or legitimacy of which depends on the mode of moral reasoning the ethicist is using… [whereas] in law, a right is any legally protected interest, usually with legally binding rules of domestic (normally constitutional) and international law requiring governments to respect, ensure, promote and fulfil certain norms, with opportunities for persons denied their rights, non-governmental organizations and various international agencies to obtain redress or change policy consistent with those norms.”

In its simplest meaning, the relationship between the moral and legal basis of human rights may be understood by considering that human rights emerge from claims of people suffering injustice, based on moral sentiment, but become part of the social order when they are incorporated into the law. Thus, the firmest basis determining whether an act or omission is in conformity with human rights standards is positive law, which is dependent upon a law making process resulting in a declaration, law, treaty or other normative instrument. The law may vary over time and be subject to derogations or

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54 Ibid.
limitations designed to optimize respect for human rights rather than impose an absolute standard.\textsuperscript{55}

Human rights are universal rights, in the sense that they are held by people simply because they are people. In the words of Jacques Maritain in ‘The Rights of Man’:

“The human person possesses rights because of the very fact that it is a person, a whole, master of itself and of its acts, and which consequently is not merely a means to an end, but an end, an end which must be treated as such. The dignity of the human person? The expression means nothing if it does not signify that by virtue of natural law, the human person has the right to be respected, is the subject of rights, possesses rights. These are things which are owed to a man because of the very fact that he is man.”\textsuperscript{56}

According to Lauren, the historical origins of the ‘visions’ of human rights emerged from a complex, myriad but also interrelated web of interactions and influences. He cites as examples religious beliefs, secular philosophical principles, or from “violence and pain from upheaval, enslavement, conquest, revolution, war, torture, and genocide”\textsuperscript{57}, and the “heat of anger generated by a passionate sense of injustice being inflicted upon innocent or defenceless victims”.\textsuperscript{58}

\textsuperscript{55} Ibid.

\textsuperscript{56} Maritain, Jacques, \textit{The Rights of Man}, (1944), London G. Bles, 37.


\textsuperscript{58} Ibid, 2.
2. Human Rights in Theory – Its Emergence and Development

2.1 Early Development

The current configuration of international human rights can be traced back to the Age of Enlightenment in the eighteenth century, where the idea of natural rights\(^{59}\) (the concept that people have certain rights by virtue of being human) was developed by European philosophers such as Jean-Jacques Rousseau and Montesquieu. This was also where revolutions of freedom and equality changed governments across Europe and North America and led to the liberation of people from the chains of slavery and colonialism in the 19th and 20th centuries. John Locke, arguably the most important natural law theorist of modern times, argued that natural law entail natural rights to life, liberty, and the pursuit of property.\(^{60}\) Upon entering civil society, humankind surrendered to the state – pursuant to a ‘social contract’ – only the right to enforce these natural rights but not the actual rights themselves. Accordingly, the state’s failure to secure these rights gives rise to a right to a responsible, popular revolution.\(^{61}\) Locke’s natural rights were derived from divinity as humans are the creations of God. His ideas influenced many other philosophers after him, such as Immanuel Kant, Thomas Paine, and the drafters of the French and American Declarations, and these various political and philosophical ideas and notions further set the path for the development of the modern concept of human rights.

\(^{59}\) To go in-depth into the concept of natural law/rights is beyond the scope of this thesis. For a read about how the theory of natural rights developed in the seventeenth century, see: Tuck, Richard, *Natural Rights Theories: Their Origin and Development*, (1979) Cambridge: Cambridge University Press.


Nonetheless, the idea of human rights as natural rights is not without its critics. It was regularly associated with religious orthodoxy, which made it less attractive to philosophical and political liberals; and natural rights were increasingly considered to conflict with one another because they were conceived in absolutist terms.\textsuperscript{62} Even though by World War I, there was hardly anyone who would defend ‘the rights of Man’ along the lines of natural law, the ideas of rights endured. Yet it was not until after World War II that the idea of human rights started to develop.

2.2 Human Rights Post World War - Its Modern Appearance

Following the end of World War II, many human rights agreements came into effect including the Genocide Convention and the Universal Declaration of Human Rights in 1948, the Geneva Conventions in 1949, and the International Covenants on Human Rights in 1966. Hence, the term ‘human rights’ replaced the phrase ‘natural rights’ which had become unpopular because the concept of natural law had become a matter of great disagreement.\textsuperscript{63}

While people may disagree as to why we have rights, there is a consensus that they are essential. Although the details of human rights belief may be debatable, the grounds for believing in human rights protection are more secure. Ignatieff argues that the basis for the modern human rights is grounded in history: humans beings are at risk of their lives if they lack a basic measure of free agency and that agency itself requires protection through internationally agreed standards.\textsuperscript{64} These standards should entitle individuals to oppose and resist unjust laws and orders within their own states. When all other remedies

\textsuperscript{62} Ibid.


have been exhausted, these individuals have the right to appeal to other people, nations, and international organizations for assistance in defending their rights.65

Today, the majority of legal scholars and philosophers agree that every human being has some basic rights. The last half of the twentieth century can be said to mark the birth of international as well as the universal recognition of human rights. For example, an agreement that all people are ‘born free and equal in dignity and rights’ was reached in 1945 when the promotion of human rights was identified as a principal purpose of the United Nations.66 One of the major achievements of the drafters of the Charter of the United Nations was the emphasis on the provisions of the importance of social justice and human rights as the foundation for a stable international order67. In 1948, The Universal Declaration of Human Rights68 was adopted as a universal standard of achievement for all people throughout all nations.

The Universal Declaration of Human Rights (UDHR) is not a legally binding instrument as such, and some of its provisions depart, or departed from then existing and generally accepted rules. For example, Article 2 provides that

“Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status”.69

65 Ibid.
69 Ibid.
This was a novelty given the racial segregation of health care provisions in the United States at that time.\textsuperscript{70} Thus, Article 2 of the UDHR illustrates how the UDHR went against many of the prevalent and established rules and customs around that time. Still, nations have endowed it with a tremendous legitimacy through their actions, including invoking it legally and politically at national and international levels. Most important is its status as an authoritative guide, produced by the General Assembly, to the interpretation of the Charter of the United Nations.\textsuperscript{71} The drafters of the Declaration reaffirmed the language of the Charter in the preamble,

\begin{quote}
“Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom”\textsuperscript{72}
\end{quote}

The reference to “social progress” was used together with the stated goal of Article 55 of the Charter, which is to promote “higher standards of living, full employment, and conditions of economic and social progress and development”\textsuperscript{73}, to make the case for the

\textsuperscript{70} For examples of how racial inequalities manifested themselves in the United States health care around the time of the signing of the UDHR see, Smith, David Barton, \textit{Health Care Divided: Race and Healing a Nation}, (1999) Michigan: University of Michigan Press, 19-20. Smith quoted an incident of a young black man who was shot in the abdomen by a gang of white youths in 1940. He was denied access to the local hospitals and consequently he died due to lack of treatment.

\textsuperscript{71} Brownlie, Ian (ed.), \textit{Basic Documents on Human Rights}, (4\textsuperscript{th} ed., 2002) Oxford: Oxford University Press, 18


inclusion of social, economic and cultural rights in the Declaration. Social, economic and cultural rights encompass human rights associated with the indispensable conditions needed to meet basic human needs such as education, food, water, shelter, clothing and health care. For example, the right to education, the right to work, the right to be free from hunger and the right to the enjoyment of the highest attainable standard of physical and mental health fall into the category of social, economic and cultural rights.

A common thread throughout this thesis is the emphasis on the importance of not undermining the right to health merely because of its status as part of social, economic and cultural rights. Improving the position of health as a human right means a major avenue for progressing society as a whole, which in turn acts as a bulwark for the implementation of other human rights today.

In its strictest sense, a declaration is a proclamation of basic principles of undeniable rights and imposes only a moral burden on member states. Yet, despite many efforts to present and portray the document as “mere” statement of principle with no legally binding authority, it quickly assumed moral, political, and even legal force through customary law, which in turn inspired a revolution in international, regional, and national actions in promoting human rights. The interesting argument that “… the UDHR, and possibly the Covenants and other human rights instruments, has become part of customary international law …” may further boost the effectiveness of the UDHR.

Customary international law and treaty law are two separate entities, but they may complement each other. This is because while universal human rights treaties have been widely welcomed, not all states have ratified them; customary international law, on the other hand, binds every state with the exception of “persistent objectors”. Additionally, various countries treat customary international law as the law of the land whereas they require treaty law to be specifically incorporated into national law.

The UDHR is the cornerstone of the human rights movement. As noted by Henry Steiner,

“No other document has so caught the historical moment, achieved the same moral and rhetorical force, or exerted so much influence on the human rights movement as a whole… bore a more radical message than its framers recognized… [working] its subversive path through many doctrines of international law, forever changing the discourse of international relations on issues vital to human decency and peace.”

Indeed, the preamble of the UDHR states that “recognition of the inherent dignity and the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world”.

Although all people are treated as equal under human rights law, human rights respect diversity in human cultures and recognize that people are different in race, colour, gender, language, religion, nationality or social origin. Therefore, the states are expected to provide equal and effective human rights protection tailored to all, regardless of

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78 Ibid, 160.
79 Ibid.
differences. Human rights address the relationship between the states and individuals. In practical terms, international human rights law defines what states can do to us, cannot do to us, and should do for us. Thus, they embrace positive and negative obligations on the part of the state.

2.3 A Divergence of Human Rights Ideologies

As a result of the Cold War, with its contradictory political ideologies, it took almost twenty years to achieve consensus on the texts of the two major human rights treaties – the International Covenant on Civil and Political Rights 1966 (ICCPR)\(^3\) and the International Covenant on Economic, Social and Cultural Rights 1966 (ICESCR).\(^4\) The ICCPR consists of the right to liberty and security, the right to a fair trial and political rights and many others; while the ICESCR consists of, amongst many others, the right to the highest enjoyment of the highest attainable standard of physical and mental health, the right to work and the right to education.

Advocates of a single covenant instead of the current two have argued that,

“human rights could not be clearly divided into different categories, nor could they be so classified as to represent a hierarchy of values. All rights should be promoted and protected at the same time. Without economic, social and cultural rights, civil and political rights might be purely nominal


in character; without civil and political rights, economic, social and cultural rights could not be ensured.”

However, the opposition took on the stance that civil and political rights are more significant, pointing to the progressive nature of the social and economic rights and doubting whether they were rights in the true sense. The division of human rights into two separate treaties illustrates the worldwide tension between the tradition of liberal states founded on civil and political rights and socialist and communist welfare states founded on solidarity and the government’s obligation to provide for basic human needs. However, acknowledgement and acceptability of the indivisibility and interdependence of the rights has once again become the norm since the end of the Cold War. As of January 2000, 144 countries had ratified the ICCPR and 142 countries had ratified the ICESCR. Accordingly, the Universal Declaration of Human Rights, the ICESCR, ICCPR and its two Optional Protocols constitute the ‘International Bill of Human Rights’. Having accounted the wider concept of international human rights, an understanding as to how the human right in focus here – the right to health – is documented in the law will be looked at in the following section.

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3. Codification of the Right to Health

3.1 International Documents:

The current catalogue of human rights consists of some fifty normative propositions enumerated in the International Bill of Human Rights, extended by a number of specialized UN treaties, several regional human rights treaties, and hundreds of international norms in the fields of humanitarian aid, refugees, armed conflict and criminal law.\textsuperscript{90} Treaties create legally binding obligations on the nations that have ratified them, thereby giving them the status and power of international law. In addition, there are many international declarations, resolutions and recommendations on human rights that, although they are not legally binding, still provide broadly recognized norms.\textsuperscript{91}

Health and governmental responsibility for health is contained in these documents in various ways. The WHO provided the first specific international health and human rights provisions in the preamble of its Constitution, declaring that “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic, or social


condition.” The right to health was further affirmed by the UDHR Article 25(1) which provides 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, and the right to security in the event of unemployment, sickness, disability, widowhood, old age and other lack of livelihood in circumstances beyond his control.”

The right to food, housing and medical care were derived mainly from the Latin American socialist tradition, while the right to clothing was first added by the Philippine delegation. Interestingly, in the original proposal by John Humphrey, a Canadian scholar and one of the principal drafters of the Declaration, the right to medical care was in a separate article from the rights to food and housing. He made some amendments to Article 16 of the proposal by the Chilean delegate which stated that “the State must promote measures of public health and safety”, changing “must” to “shall” and deleting the wording “measures of”, thus changing the sentence to “The State shall promote public health and safety”. He further added the sentence “Everyone has the right to medical care” to the beginning of the prior mentioned sentence; thus strengthening the proposed article on public health and putting the emphasis on “the right to medical care”.

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95 Ibid.
However, Humphrey’s “right to medical care” was changed into the “right to the highest attainable standard”, which differs from a right to healthcare. The drafters of the Declaration each had their own opinion on the wording for such social rights. At one point, the drafting committee believed that the Article should closely follow the Constitution of the WHO by expressly addressing the role of the community in fulfilling the right to health care. Article 33 of the WHO Constitution is drafted in similar terms (the slight difference being the WHO’s use of the word - ‘a’ right instead of the word - ‘the’ right) to the committee’s initial draft of their version of the right to health. Indeed, following the recommendation of Eleanor Roosevelt, the drafting committee proceeded with the following version (compare this with Article 33 of the WHO Constitution):

“Everyone, without distinction of economic and social condition, has the right to the highest attainable standard of health. The responsibility of the State and community for the health and safety of its people can be fulfilled only by provision of adequate health and social measures”.

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96 Ibid, 194.
99 Article 33 provides that “Everyone, without distinction as to economic or social conditions, has a right to the highest attainable standard of health. The responsibility of the State and Community for the health and safety of its people can be fulfilled only by provision of adequate health and social measures.” Constitution of the World Health Organization; adopted by the International Health Conference in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States, and entered into force on 7 April 1948. [http://www.who.int/governance/eb/who_constitution_en.pdf](http://www.who.int/governance/eb/who_constitution_en.pdf), accessed 8 January 2007.
100 Refer to Ibid.
The words “medical care” were inserted to indicate what an individual's right would be in the case of loss of health or endangered health. As with most Articles in the Declaration, the final wording of Article 25 was the result of many heated debates and numerous layers of drafts proposed by the drafting committee.

The International Bill of Human Rights complements the UDHR. One of the best known treaty provisions regarding the right to health is found in the ICESCR. Under the ICESCR, the right to social security and the right to health is recognized as an independent, but very generally formulated, right. Article 12(1) provides for “…the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”. Article 12(2) further states that:

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

(a) The provision for the reduction of the still-birth 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.”

104 Ibid.
3.2 Other Relevant International Instruments:

Under international human rights law, all people should be treated equally and given equal opportunity.\textsuperscript{105} The principle of non-discrimination is important in human rights thinking and practice, and neglect or violation of this principle can have adverse impacts for the health of the public. Discrimination occurs when an individual or a group in society is treated unfairly and unjustly on the basis of particular characteristics such as age, gender and disability, further reinforcing social inequalities. Discrimination in health provisions, including access to health centres or hospitals, or as found in programmes with direct or indirect effects on health (for example, lack of health and safety regulations or policies in the workplace), may further aggravate disparities in health.\textsuperscript{106} Examples include the withholding of immunization or other essential care or procedures from children and adults,\textsuperscript{107} or when a person experiences mediocre care or is denied treatment available to other individuals based on gender.

Following the International Bill of Human Rights, the General Assembly and other organs of the United Nations have also produced several declarations and treaties addressing the right to health of vulnerable groups such as women, children, and ethnic minorities. Article 5 of the International Convention on the Elimination of All Forms of Racial Discrimination provides that:

“… States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone,

\textsuperscript{105} Article 2 of the UDHR provides that “Everyone is entitled to all the rights and freedoms set forth in this Declaration without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status”.


\textsuperscript{107} Ibid.
without distinction as to race, colour, or national or ethnic origin … notability in the enjoyment of the following rights:

(e) Economic, social and cultural rights, in particular:

[...]

(iv) The right to public health, medical care, social security and social services” 108

Article 11.1(f) of the Convention on the Elimination of All Forms of Discrimination against Women provides for “the right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction”. 109 Article 12(1) and (2) states that:

“States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning [and] ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation”. 110

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110 Ibid.
Additionally, Article 24(1) of the Convention on the Rights of the Child recognises “the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health”.  

3.3 Regional Documents:
Regional human rights treaties also define the right to health although it was pointed out by Brownlie that the European Convention on Human Rights 1950 is essentially concerned with political and civil rights. It was only in 1961 that the European Social Charter was adopted “to protect social and economic rights”. Part I (11) of the revised Charter states that “everyone has the right to benefit from any measure enabling him to enjoy the highest possible standard of health attainable” and in (13) “anyone without adequate resources has the right to social and medical assistance”. More importantly, Article 11 provides for an obligation to ensure effective protection of the right to health, “to remove as far as possible the causes of ill health; to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health; to prevent as far as possible epidemic, endemic and other diseases…”

The African Charter on Human and People’s Rights also encompasses provisions which place State Parties under an obligation to provide health and medical services for the populations. Article 16 states that:

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114 Ibid.
“(1) Every individual shall have the right to enjoy the best attainable state of physical and mental health;
(2) State Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.”

Article 10 of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (also known as Protocol of San Salvador) provides that “Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being”. Article 10(2) provides 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.”

As indicated by the examples above, a number of regional conventions were drafted in the wake of the UDHR, each adapting ‘the right to health’ to their particular, localised aspirations. However, as the subsequent chapters will discuss, there often remains a

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disparity between these aspirations and how far their implementation has succeeded, or has been attempted, in practice.

4. The Concept of Health

The discussion of health and its related concepts is complicated by the question as to what the terms really mean. The meaning of “health” varies both objectively and subjectively depending on the context - be it genetic, natural or geographical. In conversation, the term health is used in many ways, and can mean more than just physical health, such as in reference to holistic concepts of the mind and spirit. Hence, there have been numerous attempts to provide a reasonable definition of health. The lack of precision of the meaning of health, which leads to indeterminacy of the right to health, has been used by detractors as an argument against the viability of economic, social and cultural rights such as the right to health.

4.1 Exploring the Definitions of Health

4.1.1 The ‘Naturalist’ and ‘Normativist’ Schools of Thought

Attempts at definitions will now be highlighted and discussed. There are two significant schools of thought on the theories of health in the philosophy of medicine. Naturalism focuses on explaining a subject matter as scientifically and objectively as possible. According to the naturalist, health is the absence of disease and that the term ‘disease’ can be understood objectively as biological functioning that is statistically less ordinary for the species concerned.\(^{119}\) This definition focuses on a narrow, biological state of affairs which is not subjective to external human values. Christopher Boorse\(^{120}\), the

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\(^{119}\) Lewis, Stephen, ‘Exploring the Biological Meaning of Disease and Health’, A lecture given by invitation of the Konrad Lorenz Institute, University of Vienna, 10\(^{th}\) April 2003, [http://www.chester.ac.uk/~sjlewis/Presentations/ExploringTheBiologicalMeaningOfDiseaseAndHealth.htm](http://www.chester.ac.uk/~sjlewis/Presentations/ExploringTheBiologicalMeaningOfDiseaseAndHealth.htm), accessed 6 March 2007.

\(^{120}\) It is beyond the scope of this thesis to delve deeply into the philosophy of medicine and the expansive discussions and literature on Boorse’s naturalist approach and its normative
influential advocate of naturalism, sees health as “species typical functioning”- meaning
that health is conformity with a “species design” which in modern terms means the
“… internal functional organization typical of species members, which
forms the physiology: the interlocking hierarchy of functional processes,
at every level from organelle to cell to tissues to organ…by which
organisms of a given species maintain and renew their life.”

Following from this, a disease means an impairment of the functions in the “species
design”. For example, a person who suffers from Down syndrome because of a mutation
of his genes will not be qualified as healthy because such mutation of the genes is not
part of the human design. In short, health in this sense is essentially confined to scientific
statistics.

On the other hand, the normativist school of thought approach the understanding of
health in a more subjective and holistic manner. External forces such as culture,
environment or historical background may be an influence, and health should be
characterized in relation to our social and individual needs and vital ambitions. Human
health and human disease are not remote occurrences. The environment and society may
influence man in many ways, either by directly creating illness by hurting him, or in a
more indirect and subtle manner such as setting societal goals that may determine the
health of the people. Thus, a theory of health should highlight the “subjective nature of
disease experience”.

counterparts. To read more on the naturalist school of thought, see: Boorse, Christopher, ‘Health
as a Theoretical Concept’, (1977) *Philosophy of Science* Vol.44, No.4, 542-573; Boorse,
Christopher, ‘On the Distinction Between Disease and Illness’, (1975) *Philosophy & Affairs*
Vol.5, No.1, 49-68.


Lewis, Stephen, ‘Exploring the Biological Meaning of Disease and Health’, A lecture given
by invitation of the Konrad Lorenz Institute, University of Vienna, 10th April 2003,
Nordenfelt\textsuperscript{123} states that, \textit{A} is healthy means \textit{A} has the ability to realize all those goals which are necessary for her health, and that a person’s vital goals are the “states of affairs which are such that they are necessary and jointly sufficient for the subject’s minimal long-term happiness.”\textsuperscript{124} Social values are more at play in such a definition rather than being purely statistically dependent. Nordenfelt focuses more on the positive concept of health instead of ‘disease’ or ‘disorder’, and this is arguably, the distinguishing feature.

The debate between the naturalist and normativist schools of thought is still an ongoing one and has generated an array of literature.\textsuperscript{125} However, it should be noted that it is not the purpose of this thesis to join the debate and discuss the philosophical aspects of health and medicine, but rather to sketch the various definitions of health that could arise for the stated purpose. In the following section, the development of the notion of health is considered from a historical perspective.

4.1.2 From Greek Philosophers to the World Health Organization

“The biggest mistake physicians make is attempting to cure the body without curing the mind. The mind and the body are one.”\textsuperscript{126}


\textsuperscript{126} Hippocrates, the Father of Modern Medicine.
Sigerist, a medical historian, states that health is always desirable to all. However, the “degree of desirability” and the “motivations” alter significantly and the valuation of health is subject to the “attitude towards the human body” and different “religious and philosophic factors”. He is also of the view that the best way to get a clear view of what health is and its meaning is by analysing its historical development. As early as the sixth century B.C., health was considered one of the highest goods according to the Greek philosophers. Their high valuation of health was supported by the physicians and Sigerist quotes the expression by the Alexandrian physician Herophilos: “When health is absent, wisdom cannot reveal itself, art cannot become manifest, strength cannot fight, wealth becomes useless and intelligence cannot be applied.” The physicians explained health as a state of perfect equilibrium, and thus, when the dynamics that make up the human body is perfectly synchronised, man will be healthy, whereas a disturbed balance will result in sickness. It is arguable that this is still true today because without health, no other human rights (civil and political or economic, social and cultural) can be enjoyed fully.

However, the Greek concept of an “ideal mode of living” devoted to the preservation of health in which nutrition and evacuation, exercise and rest were perfectly balanced was flawed. It was aristocratic as it was a concept of hygiene targeted for the wealthy minority and the aristocratic class and neglected the needs of the rest of the society. Still, the concept of health is a developing one. It changed and gradually broadened through the passage of history, continuing with the Romans, the medieval period, the

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130 Sigerist quoted a long passage from the Diocles’ book which supposedly demonstrated what the physicians of that time deemed as “ideal mode of living”. See *Ibid*, 60-63.
Renaissance, and the industrialization era until the present day. Health, in ancient times, was understood to encompass only the physical well-being. Since then, it has broadened to include the spiritual and mental well-being. Sigerist in his highly persuasive definition of health provides that:

“Like the Romans and like John Locke, we think of health as a physical and mental condition…Mens sana in corpore sano… But we may go one step further and consider health in a social sense also. A healthy individual is a man who is well balanced bodily and mentally, and well adjusted to his physical and social environment… Health is [not just] the absence of disease: it is something positive, a joyful attitude toward life, and a cheerful acceptance of the responsibilities that life puts upon the individual.” 131

This broader understanding of health is enshrined in the description of health set forth in the preamble of the WHO Constitution and repeated in subsequent instruments – namely, that health is a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. 132

Nevertheless, the WHO definition is not without criticisms. A right to health that is too broadly construed and lacks focus is less likely to be useful. It raises the imperative question as to ‘How could we use this definition to judge the standard of health of an individual or a population?’ Gostin is of the view that even if the WHO definition was construed as a reasonable, as opposed to an absolute standard, it is still difficult to

131 Ibid, 100.
implement and is unlikely to be justiciable.\textsuperscript{133} It was also suggested that the inclusion of
the reference to social well-being amounts to the “over-medicalization” of the domain of
social philosophy.\textsuperscript{134} Calman and Downie find the idea of social well-being difficult to utilise, as it diffusely
refers to the skills and other abilities which enable people to form friendships and relate
to other people in conversation and through the many different sorts of contacts which are
part of ordinary social life.\textsuperscript{135} Sometimes, these are called ‘life skills’ and the possession
of them help to create a sense of self-esteem which is currently a fashionable concept in
the literature of health education.\textsuperscript{136}

Callahan is sceptical of the possibility of defining strictly a word as vague as ‘health’, and
points out the lack of empirical sources for the enthusiasm behind the inception of the
WHO definition of health.\textsuperscript{137} He criticized the definition as absurd because it makes the
medical profession the “gate-keeper for happiness and social well-being” or even the
“final magic-healer of human misery”.\textsuperscript{138} It is arguable that Callahan’s conclusion that
one can still be healthy without being in a state of “complete physical, mental and social
well-being” and that health should just be “a state of physical well-being”\textsuperscript{139} does no
more than adds to the haystack confusion as to what health really means. Hence, the

\textsuperscript{133} Gostin, Lawrence, ‘The Human Right to Health: A Right to the ‘Highest Attainable Standard

\textsuperscript{134} Daniels, N, ‘Health Care Needs and Distributive Justice’, in Bayer, R, A.L Caplan and N.

\textsuperscript{135} Calman, K.C and Downie, R.S, ‘Ethical Principles and Ethical Issues in Public Health’, in Detel, Rogers, McEwan, James, Robert Beaglehole and Heizo Tanaka (ed.), \textit{Oxford Textbook of

\textsuperscript{136} \textit{Ibid}.

\textsuperscript{137} Callahan, Daniel, ‘The WHO Definition of “Health”’, in Smith, Mickey C. (ed.), \textit{Pharmacy

\textsuperscript{138} \textit{Ibid}, 98.

\textsuperscript{139} \textit{Ibid}, 103.
broad dimension of the definition of health by the WHO is used as leverage against proponents of the right to health by arguing that such vagueness does not lend credibility to what the right to health really entail and that it runs the risk of being misconstrued and abused.

Confronted with the controversies surrounding the right to health, the Committee on Economic, Social and Cultural Rights issued a General Comment No. 14\textsuperscript{140} that contributed to the discourse on the meaning of the right to health. It states that “health is a fundamental human right indispensable for the exercise of other rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity.”\textsuperscript{141} Consistent with the idea that most human rights are interrelated and interdependent, the right to health is not confined to health care, but embraces a wide range of socio-economic conditions necessary for people to lead healthy lives, including the underlying determinants of health (for example nutrition, housing, sanitation, water).\textsuperscript{142} Having examined the various approaches to the definition of health, the question arises as to whether a definition of health is required. Does a precise definition need to be in place before the right to health can be operational?

5. Is a Definition of Health Necessary?

“If we devote ourselves to finding holes exactly shaped to house such great words as Freedom, Honour, Bliss we shall spend a lifetime slipping,

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\textsuperscript{141} Ibid.
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\textsuperscript{142} More detailed discussions in section 6 of present chapter and section 4 and 5 of Chapter Two.
\end{flushleft}
and sliding and searching and all in vain. They are words without home, wanderers like the planets, and that is the end of it.”

As seen from the previous sections, the definitions of health are wide-ranging and differ in many aspects. The ones mentioned earlier are just some fraction of the whole discussion as to what health really means. Some have chosen to define health within the confines of ‘non-good’ and ‘economic good’, or even within the dimensions of theology. All these diverse theories justify a study in their own right and would thus require such a multitude of words to explore them that is decidedly beyond the scope of the present thesis. Indeed, the word ‘exploring’ was used in the title of this section because it seems more appropriate to search for the potentials available, rather than sticking to just a solid or authoritative assertion of the meaning of health.

It is arguable whether or not we necessarily need a clear definition of the word ‘health’ in order to understand the right to health better. No doubt the attempts to define health are commendable because one also needs to assess the implications from the various concepts and definitions of health. However, rather than discussing a word as vague as ‘health’ in the abstract, the practical application of the right to health should be considered. This is similar to attempts to define expressions like ‘happiness’ or ‘life’ or more specifically in this context the right to life which according to international human rights documents is the essence of all human rights.

For the purposes of this thesis, the assumption is that there is no single definitive meaning of 'health'. Rather, there is an acknowledgement that the WHO definition of health is appropriate, since at present it is still the most universally known and used in the framework of the right to health. Its virtue lies in that it places health in the widest human context possible, though its criticism noted are valid. Thus, it should not be taken literally, because this would lead to a utopian vision where one can claim that even ageing or mortality is a disease.

In sum, the right to health does not mean the right to be healthy, since being healthy is determined in part by health care, but also by genetic predisposition and social factors. The WHO definition seeks to capture the constructive connotations of health in everyday discourse, and suggests that there are ideals of health and not merely degrees of freedom from diseases.\(^{146}\) It also has important conceptual and practical implications and it illustrates the interdependence and indivisibility of rights as they relate to health. The field of social epidemiology has excelled in establishing correlations between discrimination based on race, class or gender, denial of education and of decent working conditions, as well as other factors that contribute directly to increased rates of mortality and morbidity. Hence, these social determinants may also be defined in human rights terms as deprivation of health-related rights.\(^{147}\) This shows that rights relating to discrimination, autonomy, information, education and participation are a fundamental and indivisible part of the achievement of the highest attainable standard of health, just as the enjoyment of health is equally inseparable from that of other rights, whether categorized


as civil and political or social, economic and cultural. Nonetheless, to contribute further to the implementation of the right to health, other elements of the right to health will now be considered.

6. Understanding the Contents of the Right to Health

The concept of core obligations provides a framework for thinking and understanding economic, social and cultural rights. More so compared to civil and political rights, economic, social and cultural rights contain obligations that require States to take positive actions. As these human rights may sometimes be vague and indefinite, it leaves uncertainty as to what extent and how the measures should be implemented. Understanding the core content of the right may serve as a helpful guide as to what measures States should realize immediately, irrespective of their existing resources.

At a universal level, it is difficult to be specific about the scope and the core contents of the right to health. As a consequence of the disparity in health levels and needs throughout the world, it is difficult to describe what health services States should provide on the basis of the right to health. However, ideas developed at the international as well as the national level are a good indication of the basic content of the right to health.

The Economic, Social and Cultural Rights Committee, in its General Comment No.3, was of the view 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.” The Maastricht Guidelines on Violations of Economic, Social and Cultural

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Rights further reaffirmed that “a State party in which any significant number of
individuals is deprived of essential foodstuffs, of essential primary health care, of basic
shelter and housing, or of the most basic forms of education is, prima facie, violating the
ICESCR.” There were endeavours to define the core content of some specific
economic, social and cultural rights and it raises the question as to what level of health
individuals should minimally have so that they could lead a dignified life and be able to
operate adequately in society.

At the 1977 World Health Assembly, the WHO initiated the Global Strategy for Health
for All by the Year 2000, which states that “there is a health baseline below which no
individuals in any country should find themselves” and that primary health care is
outlined as one of the key principles of Health for All. In the interpretation of this goal by
governments and the WHO, it is intended that all people in all countries should have a
level of health that enable them to work productively and participate actively in the social
life of the community in which they live. This concept and vision of Health for all was
perhaps an attempt to restore the definition of health as construed in the WHO
constitution to its original purpose. Read in conjunction with the Declaration of Alma-
Ata, it provides that primary health care is the key to attaining ‘Health for All’ as part of

152 World Health Organization, Global Strategy for Health for All by the Year 2000, (1981)
153 Taylor, Allyn L., Bettcher, Douglas W., Fluss, S., Katherine DeLand and Derek Yach,
‘International Health Instruments: An Overview’, in Detel, Rogers, McEwan, James, Robert
Oxford University Press, 379.
overall development in the spirit of social justice.\textsuperscript{154} Accordingly, primary health care is described as:

“essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford… [and that it]

… forms an integral part both of the country’s health system; [and] of the overall social and economic development of the community.”\textsuperscript{155}

Therefore, primary health care will include, \textit{inter alia}:

- education concerning prevailing health problems and the methods of preventing and controlling them;
- promotion of food supply and proper nutrition;
- an adequate supply of safe water and basic sanitation;
- maternal and child health care, including family planning;
- immunization against the major infectious diseases;
- prevention and control of locally endemic diseases and injuries;
- provision of essential drugs.\textsuperscript{156}

The legal authority for considering primary health care as a feature of States’ obligations can be found in Article 10(2) (a) of the Protocol of San Salvador\textsuperscript{157}; and Article 2(b) of the Convention on the Rights of the Child, which provides that “States Parties shall


\textsuperscript{155} Ibid.

\textsuperscript{156} Ibid.

\textsuperscript{157} See p38 of this Chapter.
pursue full implementation of [the] right, [and shall] take appropriate measures … to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care”.\textsuperscript{158} In addition, Article 25 of the Indigenous and Tribal Peoples Convention No.169 states that:

“(2) Health services shall, to the extent possible, be community-based. These services shall be planned and administered in co-operation with the peoples concerned and take into account their economic, geographic, social and cultural conditions as well as their traditional preventive care, healing practices and medicines;

(3) The health system shall give preference to the training and employment of local community health workers, and focus on primary health care while maintaining strong links with other levels of health care services.”\textsuperscript{159}

State commitment to this was endorsed in the Cairo International Conference on Population and Development. Chapter 8.5 of the Programme of Action affirmed that “[in] keeping with the Declaration of Alma-Ata, all countries should reduce mortality and morbidity and seek to make primary health care, including reproductive health care, available universally by the end of [2004].”\textsuperscript{160} Primary health care was also listed as one of the commitments of the Copenhagen Declaration on Social Development.\textsuperscript{161} It can also

be found in Chapter 2.36 (g) of the Programme of Action that “[by] the year 2000, attainment by all peoples of the world of a level of health that will permit them to lead a socially and economically productive life, and to this end, ensuring primary health care for all.”

The importance of primary health care as part of States’ obligations has been reiterated in numerous international documents and treaties. In this regard, the identification of benchmarks or core/minimum contents of the right to health can facilitate the Committee of Economic, Social and Cultural Rights in evaluating the extent of States Parties’ compliance with their obligations under the ICESCR. However, whether this concept of core contents, which forms part of the minimum essential level of the right to health and is an integral aspect of the right, has been accordingly fulfilled by States parties will be evaluated in detail in Chapter Three.

Additionally, the normative content of the right to health involves the “availability, accessibility, acceptability and quality” of public health and health care facilities, goods, and services. “Availability” means that “[f]unctioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party.” Therefore, the basic conditions necessary for health (for example water and sanitation) and functioning health services (for example hospitals, clinics and essential medications and drugs) have to be available to the people, even though the precise conditions may differ depending on numerous factors, such as

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164 Ibid.
budget, or the country’s stage of development. Equity in the distribution of health facilities, medicine, medical equipment, health workers and other public health activities is very important, especially if the State party aims to ensure universal access to available resources and services in order to provide coverage of the most important health needs of the population. In the majority of situations, construction of health facilities is based on need as determined by population density, availability of health facilities, and other factors including feasibility and status of being an administrative centre. Still, the pivotal point is that what is crucial to implement the right to health is at least existing and obtainable.

“Accessibility” of the right to health is fulfilled when health services are available to the entire population, without discrimination or physical, geographical or economic obstructions. Thus, the principle of fairness comes into play as well, and that health care services and facilities must be affordable for all, including all socially disadvantaged groups. Equity also demands that poorer households should not be burdened disproportionately with health expenses when compared to richer households.

“Acceptability” requires that health services adhere to the standards of medical ethics and are culturally suitable. This includes being “respectful of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.”

Apart from emphasizing the importance of “availability, accessibility and acceptability”, the ESCR Committee also indicated that “quality” is an important element in the content.

167 *Ibid*.
168 *Ibid*.
of the right to health. It requires health services to be scientifically and medically appropriate and to meet good quality standards. For instance, medicines being prescribed to the people must be scientifically approved and not past the date of expiration, hospital equipment must be of good quality and standard, and safe water as well as adequate sanitation must be made available.\textsuperscript{169}

It has been observed that some prudence is required when defining the concept of core contents of human rights. While academically and intellectually it may be interesting, it can be politically dangerous because State parties may claim that, apart from the core contents, the rest of the elements of the right may be deemed unimportant and thus to be neglected.\textsuperscript{170} The right to health is an inclusive right, extending 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 occupation and environmental conditions, and access to health-related education and information, including sexual and reproductive health.\textsuperscript{171}

Hence, State parties should be reminded that merely realizing the core content of the right to health is not enough and that they should do their utmost to realize the full scale of the right itself.

7. Is there a right to health? - A Debate

In 1999, a working draft was produced by the Tavistock Group concerning a set of ethical principles to guide all who influence and deliver health care. By recognizing “health care as a human right” as one of the main principles that should govern health care systems\textsuperscript{172},

\textsuperscript{169} Ibid.
\textsuperscript{171} Ibid.
\textsuperscript{172} Smith, Richard, Howard Hiatt and Donald Berwick, ‘Shared Ethical Principles for Everybody in Health Care: A Working Draft from the Tavistock Group’, (1999) \textit{BMJ} 318:248-251,
it fundamentally reaffirmed the basic idea of a human right to health. The right to health is a social obligation that extends beyond the commercial realm (States should do more than just leave it to the private sectors); it is not something that can be owned exclusively by individual providers or organizations. Therefore, it is not something that can be sold or traded monetarily to individuals or communities. Accordingly, governments have an obligation to ensure that health care as a service is rendered and remunerated fairly under its own stewardship as well as others in the health care system.

Critics and sceptics against health as a human right point to the significant differences between the two set of rights - civil and political rights on the one hand, and economic, social and cultural rights on the other. This reveals essentially the dichotomy between negative rights (civil and political), and positive rights (economic and social), especially concerning the place of obligations and duties correlative to human rights. As expressed by Fried,

“A positive right is a claim to something – a share of material goods … or perhaps the claim to a result like health … while negative right is a right that something not to be done to one, that some particular imposition be withheld. Positive rights are inevitably asserted to scarce goods, and consequently scarcity implies a limit to the claim. Negative rights, however … do not appear to have such natural, such inevitable limitations.”173

Thus, the common view is that negative rights require only an undemanding non-interference, whereas positive rights (which are often used to refer to basic social rights


such as health care, education and adequate standard of living) require a more interventionist state and demand that States provide the necessary means to those who are unable to provide for themselves.

Conservative and libertarian proponents argue that social economic rights, because of their status as positive rights, are not really human rights because they are not universal or categorical. Associated with this claim is that civil and political rights are held against everyone else and easier to enforce, while economic and social rights are held against a particular government and hence, much more difficult to implement as they involve the redistribution of resources. It is along these lines that Cranston argues that civil and political rights are universal human rights, but that economic and social rights are not.

The defence of negative rights rests on the assumption that these rights can be guaranteed through the simple expediency of passing national laws that guarantee negative freedoms.

“The traditional ‘political and civil rights’ can...be readily secured by legislation, and generally they can be secured by fairly simple legislation. Since those rights are for the most part rights against government interference with man’s activities, a large part of the legislation needed has to do no more than restrain the government’s own executive’s arm.”174

Baumrin, although addressing this question in relation to health care rather than health itself, is of the view that the right to health care is not merely a legislative creation.175 This is because legislation is usually on a national basis, therefore, a legislated right to health in, for instance, Sweden does not automatically create the right to health on anyone

in South Africa or France. So for there to be a general right to health, it must be legislated generally (for example by the United Nations and thereby applicable to all member states). The problem is that not all States are members of the United Nations and even if they are, the United Nations does not provide the means to implement the rights but it only creates the ‘rights’, and without the means to provide for the full realization of the rights, the duty is empty. 176 There is a monitoring system for economic, social and cultural rights but the United Nations does not have direct enforcement powers.177

Another argument in the libertarian’s camp is that honouring positive rights is impracticable and costly. All rights are claimed against the State and positive rights depend on the economic strength of a country; hence, setting any universal standards for economic and social rights is almost impossible. While there can be a consensus on health as a human right, attempting to answer the question as to whom the duty to provide health care to the world’s population falls on is much trickier. Should it be the duty of individual doctors, hospital authorities, every government, or only the rich governments? Because social and economic rights require onerous expenditures that many poor nations cannot afford, Cranston believes that they are not universal human rights at all.178

The issue of allocation of resources raises the question as to how much of a particular resource can be rightfully claimed to realize the right to health. As in economics, opportunity cost exists in this area as well, and resources spent on one right means less resources are available for other rights. Do all individuals have a right to organ transplant,

176 Ibid.
177 See section 3 of Chapter Two, pp. 88 – 94.
access to treatment of cancer, or the access to reproductive technology that allows infertile or same-sex couples to have children? A scenario of demand out-competing supply is unreasonable on the State’s resources. However, such worry is unfounded because as has been seen, fulfilling a right to health does not mean that everybody has universal access to the latest technological and scientific resources for health. Instead, it refers to the provision of the minimum basis required to lead a dignified life.\textsuperscript{179}

Furthermore, the theoretical distinction between negative and positive rights is questionable because many classical negative rights also require some kind of public funding and State intervention. To ensure the enjoyment of civil and political rights, stable, rights-respecting institutions must be set up and staffed by individuals trained to uphold them and to hear grievances of any violations. In many places, such institutions may not even exist and cannot be established overnight or via simple legislation\textsuperscript{180}. As observed by McBride,

\begin{quote}
“The need for expenditure is clearly evident in rights such as that to a fair hearing before an independent and impartial court, funds will be required not only for the buildings and personnel which constitute a court system but also for the provision of legal aid and interpreters…”\textsuperscript{181}
\end{quote}

Other examples to illustrate this point further would be the right to physical security as well as property rights. Effective enforcement and protection of these negative rights would need “positive” programmes such as detailed registration and protection tools,

\textsuperscript{179} See section on understanding the content of the right to health – section 6 of current chapter.
which are usually funded by the State. The right to physical security would necessitate police forces, criminal courts as well as rehabilitation facilities for offenders, and this may involve costly expenses.\textsuperscript{182} In short, the distinction between the two sets of rights is a weak point to establish the relative importance of human rights. As illustrated in this paragraph, civil and political rights (which are negative rights according to classical conventions) also incur public spending and State involvement just like positive rights such as economic, social and cultural rights. Besides, one cannot simply categorize one human right as more important than the other as they are all interconnected and interrelated.

The issue of limited public resources arises for civil and political rights as well; accordingly, the protection of both negative and positive rights requires the expenditure of collective resources. There should be no incoherence in understanding human rights as entitlements to be progressively achieved.\textsuperscript{183} Costs incurred in fulfilling the rights do not mean the giving up of the human right project; but rather, it merely implies that the enjoyment of human rights will not be achieved upon the signing of a treaty.

Cranston also dismissed economic and social rights as being universal because such rights are not of “paramount importance”. According to him, “A human right is something of which no one may be deprived off without grave affront to justice.”\textsuperscript{184} Civil and political rights, such as the right against torture, pass the test of paramount importance.


\textsuperscript{183} See discussion on the principle of progressive realization of right – Chapter Two.

\textsuperscript{184} Cranston, Maurice, \textit{What are Human Rights?}, (1\textsuperscript{st} ed., 1973) London: The Bodley Head Ltd, 68.
“The use of torture at the pleasure of a despot is precisely the kind of thing which the Declaration of the Rights of Man is meant to outlaw, and which the United Nations at its inception was expected to banish from the earth. This is a matter of moral urgency, which is far removed from a question of holidays with pay.”

As economic and social rights are, in his view, merely goals and not a matter of urgency, they are by definition not universal human rights. This is in accordance with the liberal consensus, which relegates social and economic rights to the status of legitimate aspirations, and that negative rights outrank positive rights. This is further strengthened by the argument that civil and political rights are fundamental elements of democracy, and that they are constitutionalized, because personal autonomy requires them to be. If one is unable to express oneself, or move about freely; one would be unable to make relevant decisions about one’s life and to implement these decisions.

Consequently, the liberal camp contends that the resolution of economic and social goals is best achieved by promoting civil and political rights, which will lay the groundwork for better economic growth, higher incomes and lower unemployment. Economic growth therefore promotes the realization of positive aspirations by generating the wealth that increase people’s access to health care, nutrition and better housing; or indirectly via the improvement and extension of these facilities to a wider audience. Therefore, the fulfilment of the right to health is not a human right, but rather an aspiration for every society.

185 Ibid, 71.
The liberal consensus argues that the right to health is a philosophically highly problematic concept, emphasizing that rights are meaningful only when a duty to fulfil a claim is clearly established. For instance, the right to life merely requires third parties to refrain from killing the holder of this right. Lack of resources therefore is not an issue that can reasonably put into question the respect for and implementation of the above-mentioned right. However, this appears unachievable with regards to economic and social rights as there is no identifiable duty holder responsible for upholding them. Scarcity of resources is inevitable because there are constant developments in new scientific or disease discoveries and ensuring a certain level of health for all is simply not within the sphere of social control. Accordingly, it seems to make little sense to claim that people have a universal right to health.

Furthermore, it is arguable that the distinction between the two sets of rights is flawed, assuming that economic and social rights are just as important as civil and political rights. The difficulty of providing adequate nutrition and health care (as part of the right to health) or housing due to problems of scarcity cannot be used as an excuse to dismiss them as rights. While it will be hard to achieve a perfect score in defending the right to physical security, it will be unusual to argue that this justifies the rejection of the right. Vincent doubted the helpfulness of this distinction between rights in establishing the relative importance of human rights. As mentioned earlier, the supposedly negative civil and political right may require “positive” provisions in order to ensure that the right can be comfortably enjoyed. Nevertheless, as Fried put it, “Thus it might be said that I

have a negative right not to be deprived of a minimal diet… And indeed, every positive right might be cast in terms of a negative right not to be deprived of the good claimed.”  

The supposedly positive economic and social right can also be phrased as the right not to be deprived of something, so that a person may provide for oneself. 

Again, proponents of the primacy of civil and political rights neglect the fact that the two sets of rights are interdependent and there are basic rights without which no other rights can be enjoyed. For instance, it makes no reasonable sense to speak of a right to liberty, when there is no reliable expectation about the maintenance of life, and logically, the right to life cannot be fully separated from the basic right to food, shelter and the conditions for good health. Fabre argued that if personal autonomy is powerful enough to justify constitutionalizing civil and political rights, it should justify allocating people social rights to decent levels of minimum income, housing, education and health. If one is malnourished, thirsty, sick and illiterate and if one constantly lives under the threat of poverty, one cannot make long-term choices or decide on a meaningful conception of the good life, thus having little control over one’s existence. Jones said that individuals who lack guarantee of access to economic and social means are subjected to a dependence on the powerful. Failure to recognize economic and social rights curbs …

“liberties in a very real sense, since a lack of [such rights] leaves non-state collectivities, other individuals, and especially governments free to deny people the means to the minimum requirements of existence and thereby to coerce the helpless (or potentially helpless).”

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191 Ibid.
Hence, if access to the basic material needs of life are not protected, it renders individuals vulnerable in a way that threatens the integrity of any claim that other rights, such as civil and political, are defended. In short, economic and social rights are vital because without them, people would be unable to develop the crucial physical and mental capacities needed to be autonomous. They should be valued equally because they embody the preconditions for civil and political rights, and this argument will be investigated further throughout this chapter.

Summing it up for this section, the debate as to whether there is a right to health continues with the positive (economic and social) rights and negative (civil and political) rights discussion. Arguments for the prevalence of civil and political rights over economic and social rights reveal a “liberal habit of thought”193 that dominates human rights talk, not just in the academic field but also within political circles. Following the liberal consensus, the right to health (due to its position as an economic and social right) is not a universal human right at all and merely holds the status of legal aspiration. Impracticality, high costs of implementation as well as its relativity to scarcity are cited as reasons to reject economic and social rights. Civil and political rights play an integral role in society and the upholding of democracy; however, it is hard “to find any rational or utilitarian basis for viewing health care in the same way.”194 Evidence of the dominance of the liberal view is seen when one looks at the damaging effects for health and other social needs, which are brought about by the spread of free market ideology into everyday lives. This is why Chapter Three of the present thesis on globalization and

its effects on the right to health, either directly or indirectly, is crucial to show the link between human rights and modern global socio-economic realities.

At first sight, the liberal consensus appears compelling. However, numerous loopholes in each of the liberal claims have been pointed out above, convincingly dispels the notion of defining human rights as solely civil and political rights. The dichotomy between the two sets of rights is born out of the Cold War; although this is an important part of world history, the differences between the dominant ideologies of that era should no longer be an excuse to dismiss economic and social rights as mere aspirations; and the ideological aversions towards giving concrete relevance to economic and social rights should be a thing of the past. Advocates of positive rights provide the persuasive counter-argument that both sets of rights are interconnected and interdependent; hence, no one can fully enjoy any right if one lacks the essentials for a healthy and decent life in the first place – civil freedoms cannot be exercised if basic rights are non-existent. This is further supported by the recognition by the Vienna Declaration and Programme of Action 1993\textsuperscript{195}, which states that: “All human rights are universal, indivisible, 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.”\textsuperscript{196}

The enshrinement of economic, social and cultural rights in numerous international documents and treaties, as seen earlier in this chapter, marks its importance in international human rights law arguments that ‘the right to health is a positive right and thus not universal’ is open to challenge. General Comment No.14\textsuperscript{197} provides that the


\textsuperscript{196} Ibid.

right to health should not be viewed solely as a positive right as it contains both freedoms and entitlements. Accordingly, the freedoms include “the right to control one’s health [and] to be free from interference”; whereas 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.”

In short, economic, social and cultural rights are not mere aspirations, but should be seen as legal entitlements of human rights, inherent in human freedom and dignity. Kofi Annan, the former United Nations Secretary General once proclaimed, “It is my aspiration that health will finally be seen not as a blessing to be wished for; but as a human right to be fought for.” This sentence captures the essence of the importance of health as a human right and this is especially resounding for the millions of people who are fighting the everyday challenges of the phenomenon commonly described as “globalization” and its ill-effects towards international public health.

8. Concluding Summary

The challenges facing the promotion and protection of economic, social and cultural rights cannot be tackled strategically, without at the same time seeking to clarify the content and significance of the right to health. The human right to health, which does not seem to fall into the traditional categories of human right norms, encompasses numerous important, yet highly complex issues – hence, Chapter Two will systematically navigate through these.

\textsuperscript{198} Ibid.

\textsuperscript{199} This rhetoric adapted from a speech made by Kofi Annan is used by many non-governmental organizations on health and human rights as their vision statements and can be found in their official websites.
Chapter Two – Towards a Further Understanding of Health as a Human Right

Introduction

The previous chapter provided an overview of the various international human rights documents, treaties and norms, which define the parameters of the human right to health. The range of existing instruments show that the importance of health as a human right is comparable to other human rights. As discussed in Chapter One, some of the criticisms aimed at the notion of the right to health are based on the vagueness of the word ‘health’ and the broad definition by the WHO. Because the definition of health is unclear, Chapter One discussed the possible definitions of health. It also considered the contents of the right to health rather than provide a definitive statement of what the term health means.

An analysis was also made of the liberal arguments that reject the notion of a right to health (as part of economic, social and cultural rights) as universal and justiciable human rights as well as the counter-arguments that challenge the liberals’ views.

This chapter examines the principle of ‘progressive realization’ enshrined in Article 2(1) of the ICESCR. The ICESCR is one of the best known human rights documents concerning the right to health. The right to health has been criticized as flawed because this principle, due to the indistinct manner it was phrased in the ICESCR, provides a leeway for States parties to avoid fulfilling their obligations to ensure the right. Questions surrounding the interpretation of the treaty texts are usually concerned with how ‘immediate’ economic, social and cultural rights are supposed to be implemented. Hence, this chapter considers the principle of ‘progressive realization’ used in the ICESCR and to further understand its implications for States parties.
Additionally, as the right to health is a human right enshrined in various international human rights law, it is imperative to clarify in detail the obligations of States parties resulting from the human right to health. The monitoring mechanism of the right to health is considered to ensure that its role and purpose in ensuring this right is understood properly.

The question remains as to whether the right to health is an enforceable legal right. Hence, this chapter also examines the case law where the right to health has played a part, especially in the context of the developing world.

1. Progressive Realization

The right to health in the ICESCR is subjected to the principle of progressive realization. Article 2(1) of the ICESCR reads:

“Each State Party to the [ICESCR] undertakes to take, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the [ICESCR] by all appropriate means, including particularly the adoption of legislative measures.”

Reading this together with Article 12(1) of the ICESCR, means that States parties who accept treaty obligations for a lengthy list of rights by ratifying the ICESCR, should realize the right to health in a “progressive” manner “to the maximum of their available resources”. It is arguable that the implementation of economic, social and cultural rights

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specifically the right to health is flawed. This is because the clause may provide a loophole for States parties to shun away from fully complying with the treaty obligations. Various authors have commented that this can be contrasted with Article 2 of the ICCPR, which requires an immediate obligation to respect and ensure all rights. 201 In the General Comment No.3 on the nature of State obligations under Article 2(1), the Committee of Economic, Social and Cultural Rights explains the difference:

“The concept of progressive realization constitutes a recognition of the fact that full realization of all economic, social and cultural rights will generally not be able to be achieved in a short period of time. In this sense the obligation differs significantly from that contained in Article 2 of the International Covenant on Civil and Political Rights which embodies an immediate obligation to respect and ensure all of the relevant rights.” 202

As mentioned by Alston and Quinn, it was agreed during the drafting of the Article that implementation at the earliest possible moment was implicit in Article 2 of the ICCPR. 203 On the contrary, the word “progressively” may enable States parties to postpone their obligations indefinitely, hence, weakening the strength of the Covenant. This is one of the main differences between the two covenants and adds to the argument that economic, social and cultural rights are too vague to be characterized as legal obligations.


Additionally, they are incapable of being protected or upheld and this makes the obligation to guarantee economic, social and cultural rights impossible to achieve.

It can be argued that the wording of Article 2 of the ICCPR carries more weight for the implementation of rights than Article 2(1) of the ICESCR. Article 2 (2) of the ICCPR provides that States parties “undertake to take the necessary steps” to implement “such legislative or other measures as may be necessary to give effects to the rights recognized”\textsuperscript{204} in the Covenant.\textsuperscript{205} On the other hand, the ICESCR provides for States parties to undertake to take steps “by all appropriate means” to comply with the treaty obligations.\textsuperscript{206} The difference between the words “necessary steps” and “by all appropriate means” is that the former imply a stronger message of taking essential steps to comply with responsibilities and obligations to fulfill rights when compared with the latter. This leaves open the question as to whether the clause of the ICESCR is adequate to ensure the applicability of economic, social and cultural rights.

The principle of progressive realization also allows States parties to claim insufficient resources or funds as a legitimate reason for not complying with treaty obligations concerning the right to health. Governments have to make difficult decisions on how to allocate limited public resources. Budgetary considerations must be considered in discharging States’ duties to achieve progressively the full realization of various human rights, especially if a State has yet to reach a particular level of economic development.


\textsuperscript{205} For further reading, see: Schachter, Oscar ‘The Obligation of the Parties to Give Effect to the Covenant on Civil and Political Rights’, (1979) American Journal of International Law, Vol.73, No.3, 462-465.

However, it has been argued that the need to take into account developing countries and their relative incapability to meet immediately the obligations of the Covenant may provide an excuse that could be abused by those in better economic positions.  

In the preparatory stage of Article 2 of the ICESCR, the Soviet representative argued that while the United States contended that under-developed States would be unable to implement the rights, very few under-developed countries made that contention or supported it and many were willing to accept the ICESCR. Furthermore, as proposed by the Yugoslavian representative, the remedy should not be “a general clause permitting all states to evade their responsibilities, but provisions in specific articles permitting only the under-developed countries to delay the full implementation of the right enunciated in those articles.” To sum it up, States parties are the ones who determine how much public funds are allocated for which purposes and what constitutes the “maximum of its available resources”. Hence, governments cannot be ordered under the ICESCR to spend more money on health or to pursue more health policies than what they deem appropriate according to the “maximum of its own resources”. The fear is that States who do not fall into the category of under-developed may capitalize on this loophole of the ICESCR and delay the fulfillment of their treaty obligations.

The principle of progressive realization is weakened further because of the difficulty of measuring the progressive realization of the right to health. Expectations and obligations of States parties to implement the right to health are not in a uniform standard but are subjected to the countries’ level of development and available resources. As Chapman

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208 Ibid.

209 Ibid.
explains, this would require the creation of a range of performance standards to fit the various social, developmental, and resource conditions of specific countries.\footnote{Chapman, Audrey, ‘A “Violations Approach” to Monitoring the International Covenant on Economic, Social and Cultural Rights’, (1996) \textit{Human Rights Quarterly}, Vol.18, No.1, 23-66.} It gets more complex because to be able to fully assess whether a country is moving progressively towards full realization of the right to health, the monitoring body needs to analyse complex statistical data for several years. However, governments may not have data of the right quantity and quality needed for such analysis; or if they do, there is no guarantee that they will hand everything to the monitoring organizations. Besides, national averages, which usually only show a general overview of the country’s population data, may not be representative of the complete picture unless they are disaggregated into specifics categories of gender, race, regions, socio-economic groups or urban/rural divisions.

Hence, it can be argued that the unrestricted character of economic, social and cultural rights and the flexibility and discretion left to States under the principle of progressive realization create a loophole in the implementation of the right to health. This is because it makes rights difficult to define and enforced under international human rights law.

On the other hand, the principle of progressive realization should not be dismissed as a weakness of the implementation of the ICESCR and accordingly the right to health. Article 2 of the ICESCR can imply that the right to health, as established by that instrument, is to be realised only once a State party reaches a certain stage of economic development. However, this does not accurately reflect the clear duty on all States parties...
to act as expeditiously as possible towards the realization of the right to health, irrespective of their current stages of development.\textsuperscript{211}

The phrase “progressively” should not be interpreted as depriving the obligation towards the right to health of all meaningful content. According to the General Comment No.3, the principle of progressive realization is:

“… on the one hand a necessary flexibility device, reflecting the realities of the real world and the difficulties involved for any country in ensuring full realization of economic, social and cultural rights. On the other hand, the phrase must be read in the light of the overall objective, indeed the \textit{raison d'être}, of the Covenant which is to establish clear obligations for States parties in respect of the full realization of the rights in question.”\textsuperscript{212}

Therefore, the phrase “achieve progressively” is understood to require States parties to move as expeditiously as possible towards the realization of the rights under the ICESCR. General Comment No.3 also stipulates that the steps towards the goal of full realization of the rights “must be taken within a reasonable short period of time”\textsuperscript{213} after the ICESCR entry into force. Additionally, the ICESCR is reinforced by the Limburg Principles, which state that all States parties are obliged to begin immediately to take steps to fulfill their obligations.\textsuperscript{214} Hence, despite doubts to the contrary, there are attempts being made to strengthen and improve the implementation of Article 2 and to ensure that States parties do not deflect their obligations to fulfill the right to health.


\textsuperscript{212} Office for the High Commissioner of Human Rights, General Comment No.3: The Nature of States Parties Obligations (Art.2, Para.1), adopted on 14 December 1990.

\textsuperscript{213} \textit{Ibid}.

During the drafting process of the ICESCR, supporters of progressive realization denied that it might deter, rather than help, the cause of economic, social and cultural rights. It is true that many of the human rights contained in the ICESCR can only be achieved progressively - the right to health is not something that governments will be able to make a reality for everyone overnight. Nonetheless, Mrs. Roosevelt, the US representative, failed to see any danger in the use of the word “progressively”, and insisted instead that it “merely specified what was implicit in several of the draft articles, namely that some of the [rights] could not be enacted into law immediately.”\textsuperscript{215} The obligation of progressive realization has different implications depending on the level of resources available. Still, this does not detract from the requirement that States parties begin, in good faith, to do everything within their present power to implement the rights of the ICESCR. In this case, the most logical step will be the adoption of relevant legislation.

Similarly, to the ICCPR, the implementation of legislative measures is important to put into operation the rights contained in the ICESCR. The ICESCR recognizes that in fields such as health and the protection of mothers and children, legislation is an “indispensable” element.\textsuperscript{216} However, legislative measures alone are insufficient to fulfill the obligations of the Covenant. Accordingly, steps towards the achievement of the goal of full realization of the right to health should include administrative, judicial, social and educational measures.\textsuperscript{217}

Finally, when Article 2(1) of the ICESCR requires each State party to take steps “to the maximum of its available resources” to “achieve progressively the full realization of the


\textsuperscript{216} Office for the High Commissioner of Human Rights, General Comment No.3: The Nature of States Parties Obligations (Art.2, Para.1), adopted on 14 December 1990.

\textsuperscript{217} Ibid.
rights”, it also raises the question as to what resources are available to the State. A common misunderstanding is that economic, social and cultural rights must be provided by the State. This has led some critics to raise the problem of allocation of resources and that such rights should not form part of human rights, properly speaking, because they are expensive and will lead to an overgrown State machinery.218 In reality, different States have different levels of resources available. This does not depend only on the Gross National Product of the society concerned, but also on the amount of resources made available to the State for the pursuit of its responsibilities under international human rights law. Besides, “its available resources” also refer to the resources available from the international community through international co-operation and help.

As mentioned earlier, Article 2(1) was intended to consider the needs of the underdeveloped States parties in their pursuit of realising the Covenant’s rights. To avoid excessive idealism and to accommodate the text to the changing realities of economic conditions, the drafters of the ICESCR did not intend to let states arbitrarily and artificially determine for themselves the level of commitment required by the Covenant. States parties are obliged, regardless of their level of economic development, to ensure respect for minimum subsistence rights for all.219 This means that States have a minimum core obligation to respect and ensure the satisfaction of at least the minimum levels of the rights of the ICESCR.220 Thus, a State party, in which a significant amount of its

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population is deprived of essential primary health care, is prima facie accountable for failing to discharge its obligations under the Covenant.

Arguments can be seen on both sides with regards the effectiveness of the principle of progressive realization towards the full realization of economic, social and cultural rights, specifically the right to health. While critics are skeptical that Article 2 of the ICESCR may serve as an escape clause or a delaying tactic for States Parties to fully comply with the treaty obligations, supporters of the idea of progressive realization deem it otherwise. It was seen and defended as a necessary adjustment to the vagaries of economic situations, and that any interpretation of the clause in a manner that implies postponement of efforts to ensure the enjoyment of the right to health would be inconsistent with the clear intention of the ICESCR. Consequently, this will also be incompatible with the basic principles of international treaty law (such as the UDHR).

The above-mentioned criticism, while it mainly bases its argument upon the alleged vagueness of the right to health as part of the ICESCR, is to a certain extent politically motivated. However, it also addresses an important point, which is the need for specificity in terms of defining human rights. It is only by understanding the full content of the right to health that one can draw conclusions as to the nature of States parties’ obligations; how that right can be violated; and the means by which is can be more effectively implemented. Paul Hunt, in his Preliminary Report on the Right to Health clarifies that,

“Although subject to progressive realization and resource constraints, the right to health imposes various obligations of immediate effect. These immediate obligations include the guarantees of non-discrimination and
equal treatment, as well as the obligation to take deliberate, concrete and
targeted steps towards the full realization of the right to health, such as the
preparation of a national public health strategy and plan of action.”221

These sections should be read simultaneously to understand that the right to health is not as vague as claimed and is equally important as civil and political rights. To facilitate this, the next section considers the responsibilities and obligations of States parties under human rights law.

2. Obligations for Health under International Human Rights Law

In order for human rights principles to be constructive tools in relation to policy-making, programs and practices, and to realize the various aspects of the right to health as fully as possible, it is imperative to understand what obligations and responsibilities result from this right. The right to health, like all human rights, imposes three types of obligations on States parties: the obligation to respect, to protect and to fulfill. Hence, governments are legally responsible to comply with this range of obligations for every right in every human rights document ratified. When States seek to implement these obligations in national law, they are required to impose duties on persons subject to their jurisdiction.222

Duties to respect the right of others and duties to contribute to the common welfare make it possible for the State to help and to provide in ways, which allow everyone to enjoy economic, social and cultural rights.223

223 Ibid.
However, in today’s era of globalization, it is not as simple as just States parties and their respective governments making decisions and executing them. As will be seen in Chapters Three and Four, States’ actions in some areas of health are in practice influenced or taken by commerce representatives negotiating trade agreements, legislatures passing legislation, judicial and other tribunals deciding specific cases, and policy-makers responsible for health budgets and programming.\textsuperscript{224} Decision-makers in international organizations face various issues relating to health on a daily basis, and a tangible standard of human rights and its workings must be made applicable to the issues at hand. Understanding the outlines of different actors’ obligations under international law helps to smooth the work of policy-makers and adjudication bodies, seeking to form and implement policies in this field that are in line with both a general human rights frameworks and with specific standards.\textsuperscript{225} This section analyzes the tripartite framework of governmental obligations with regards the right to health, and specific attention is focused on Article 12 of the ICESCR.

\subsection*{2.1. The Obligation to Respect}

Respecting the right to health means that a State cannot violate, directly or indirectly, the enjoyment of that right. According to the Committee on Economic, Social and Cultural Rights, the obligation to respect requires that States refrain from

\begin{quote}
“denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; [and] abstaining from
\end{quote}


\textsuperscript{225} \textit{Ibid}. 
imposing discriminatory practices relating to women’s health status and needs.”

Thus, when a government is responsible for providing basic medical care to groups such as women and children, but it arbitrarily decides to withhold that care, this will amount to a violation of the responsibility to respect the right of health. By ratifying the ICESCR, States shall eliminate *de jure* discrimination by abolishing any discriminatory laws, regulations and practices affecting the enjoyment of the right to health. The provisions of health services should be ensured to all populations equally and free from any form of discrimination and special attention needs to be drawn to marginalized and vulnerable groups.

Resolutions passed by the United Nations provide further guidance for States in carrying out their obligations. To illustrate, a 2002 resolution by the United Nations Commission on Human Rights stated that

“…access to medication in the context of pandemics such as HIV/AIDS is one fundamental element for achieving progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”

The resolution calls upon States to pursue policies which promote “the accessibility to all without discrimination, including the most vulnerable sectors of the populations, of such

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pharmaceuticals or medical technologies and their affordability for all, including socially
disadvantaged groups” 229 and to “refrain from taking measures which would deny or limit
equal access for all persons to preventive, curative or palliative pharmaceuticals or
medical technologies used to treat pandemics…” 230
The State is also obliged “to refrain from prohibiting or impeding traditional preventive
care, healing practices and medicines, from marketing unsafe drugs and from applying
coercive medical treatments, unless on an exceptional basis for the treatment of mental
illnesses or the prevention of communicable diseases.” 231 A violation of this right may
occur when State-owned pharmaceutical companies market or provide unsafe
medications to the people. Another example of a violation is when discounted drugs
given to a government are sold to unregulated local retailers, who then re-export it
outside of the country for additional profits, instead of aiding the people in the country
who are desperately in need of affordable and accessible drugs. 232
States should also avoid “unlawfully polluting air, water and soil, e.g. through industrial
waste from State-owned facilities, from using or testing nuclear, biological or chemical
weapons if such testing results in the release of substances harmful to human health, and
from limiting access to health as a punitive measure…” 233 Hence, the people whose
health are affected as a result of coming into contact with chemical and industrial wastage
should be given the chance to seek recourse against the State’s violation of its obligation.

229 Ibid. ¶ 2(b).
230 Ibid. ¶ 3(a).
231 U.N Committee on Economics, Social and Cultural Rights, General Comment No.14: The
Right to the Highest Attainable Standard of Health, adopted on 11 May 2000, UN Document
232 Access to medicines is dealt with in detail in Chapter Four. Also see: Wendo, Charles,
233 U.N Committee on Economics, Social and Cultural Rights, General Comment No.14: The
Right to the Highest Attainable Standard of Health, adopted on 11 May 2000, UN Document
A violation of the obligation to respect also occurs when States “repeal or [suspend] legislation necessary for the continued enjoyment of the right to health or adopt legislations or policies which are manifestly incompatible with pre-existing domestic or international legal obligations [relating] to the right to health.” For example, if a community is afflicted by major infectious diseases, and yet laws and policies are implemented which result in the people having to pay higher prices in order to be immunized, this will constitute a violation of the State’s obligation under the ICESCR. The General Comment No.14 also provides further examples of violations of the responsibility to respect the right to health, which includes

“…the deliberate withholding or misrepresentation of information vital to health protection or treatment… and the failure of the State to take into account its legal obligations regarding the right to health when entering into bilateral or multilateral agreements with other States, international organizations and other entities, such as multinational corporations.”

This statement implies that the United Nations recognizes the growing influence of multinational corporations on the decisions and policies of governments and the influence they yield, which may have detrimental effects on the health of the people. Thus, governments have a responsibility to consult the public and to take actions to ensure that people’s access to any form of health facilities are not jeopardized, before signing any trade agreements which may have the likelihood of forcing changes in government plans, and which may in turn affect the health of the people.

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234 Ibid.
235 Ibid.
236 See Chapter Three which discusses globalization and its effects on the right to health.
Most countries, whether developing or developed, cannot argue that health care access is equal to all. For example, the treatment of mental disorder in prisons illustrates how a demarcation exists between health care access in prison and out of prison. A study investigating the facilities for in-patient care of mentally disordered people in thirteen prisons with in-patient beds in England and Wales revealed that the quality of service for mentally ill patients fell below the standards of the National Health Service (also known as NHS). One may argue that if a person is in prison, how can one expects the same treatment as an individual not in prison. Thus, there are instances when the right to respect the right to health does not necessarily translate into reality. Nonetheless, the essence of the obligation to respect (as stated in General Comment No.14) means that all individuals, including prisoners, are entitled to the enjoyment of the right to health without discrimination. Hence, governments should make the efforts to bring prison health care up to acceptable standards.

2.2 The Obligation to Protect

State parties to the ICESCR have a responsibility under international human rights law to protect the enjoyment of the right to health. This means that States have to take the necessary measures to prevent private individuals or businesses from interfering with the right to health, and that they would have the responsibility for ensuring some form of redress that the people are aware of and may resort to in the event of such violations. In the General Comment No.14, the obligation to protect was clarified to include, *inter alia*:

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237 The study showed that facilities were often poor, staff numbers were low, and many staff had not completed specialist psychiatric training. Patients spent too much time locked up and had insufficient therapeutic activity: Reed, John and Maggi Lyne, ‘Inpatient Care of Mentally Ill People in Prison: Results of a Year’s Programme of Semistructured Inspections’, (2000) *BMJ* 320:1031-1034.

“… [Adopting] legislation or [taking] other measures ensuring equal access to health care and health-related services provided by third parties; [ensuring] that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; [controlling] the marketing of medical equipment and medicines by third parties; and [ensuring] that medical practitioners and other health professionals meet appropriate education, skills and ethical codes of conduct.”

A violation of this obligation occurs if States do not have appropriate checks in place when health care services in the country are subject to privatization. States must ensure that even if health care facilities are privatized, there should be alternative provision for those who cannot afford private health care. Rising costs of medicines and health care may impede the enjoyment of the right to health. That is why the availability and accessibility of essential medicines should be monitored by the States and that the marketing of medicines be controlled via relevant legislative measures and policies.

Further examples of what constitute violations of the obligation to protect are

“…failure to regulate the activities of individuals, groups or corporations so as to prevent them from violating the right to health; the failure to protect consumers and workers from practices detrimental to health; [and] the failure to enact or enforce laws to prevent the pollution of water, air and soil by extractive and manufacturing industries.”

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240 Ibid.
In many developing countries, the collapse of the public sector may lead to the emergence of an unsystematic, unregulated and even chaotic provider market, especially at the primary level of health care.\textsuperscript{241} In some instances, it has also resulted in governments relying upon Non-profit organizations (hereinafter known as NGO), UN agencies, charities, religious groups and humanitarian organizations to fill in the gaps in public provision, not only in primary care but also in crucial hospital services and in response to humanitarian emergencies.\textsuperscript{242}

While this may be beneficial - as it fills in the gaps of inadequate public health services - there is also the danger that a private provider that is too profit-oriented may result in health policies that focus only on income maximization, while neglecting maximum accessibility and affordability of those in need.\textsuperscript{243} States should have legislative or other measures in place to prevent the infringement of the right to health of the people in the event that extreme commodification of health care results in the public being denied necessary medical and health care needs, or that individuals or certain segments of society are being excluded from basic health services. States have the responsibility to ensure that the accessibility and quality of health care services are safeguarded. Without proper enforcement or a functioning regulatory system, the State runs the risk of falling short of its international obligation to protect the right to health. In general, States should have the welfare and interests of the people at heart, and should accordingly enact legislative and other measures to protect the people from harmful health infringement by any third parties.

\textsuperscript{242} \textit{Ibid.}
\textsuperscript{243} See Chapter Three regarding the commercialization of health care facilities and its possible ill-effects on the right to health.
States must ensure that the public has access to affordable health care facilities and services on a non-discriminatory basis. They must also have relevant laws in place to ensure that medicines being approved are of safe quality and standard and to take actions against third party actors who harm the public by distributing or selling tainted medicines. To illustrate, a particular medicine that was approved to be distributed and sold to the public, turned out to contain unauthorized and harmful substances that could jeopardize the health or even cause deaths for its users. The State has an obligation to protect the right to health of the public by ensuring that the relevant actions are taken against the wrongdoers and that the tainted drugs are removed from the shelves. If the State is the one who approves the drugs without the relevant checks in place, it fails in its responsibility to protect the right to health. A neglect or violation of rights directly affects public health.

2.3 The Obligation to Fulfill

The obligation to fulfill the right to health means that a State must take all appropriate measures in order to facilitate and promote the right to health. This may involve the State taking legislative, administrative, budgetary and judicial steps towards the fulfillment of the right. This obligation requires States Parties to “[recognize sufficiently] the right to health in the national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realising the right to health.”


A violation of this obligation happens when there is:

“insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the right to health by individuals or groups; the failure to monitor the realization of the right to health at the national level, for example by identifying [the relevant] indicators and benchmarks; … [and] the failure to take measures to reduce the inequitable distribution of health facilities, goods and services.”

A State falls short of its responsibility under international human rights law if too little of its national budget is allocated to health. For example, Country X is not at war, not currently facing a threatening stand-off and its people are still struggling in their fight against infectious diseases such as AIDS or malaria. However, the country still allocates the bulk of its budget to military expenditure instead of providing health services to the people. Consequently, the rate of infectious diseases continues to rise and the health of the people fails to improve. In such cases, it can be argued that the State has not spent its budget appropriately and has thus violated its obligation to protect the right to health.

As well as the specific provisions of General Comment No.14, the obligation to fulfill the right to health has also been the subject of statements and guidelines issued by charter-based bodies of the United Nations. An international guideline was issued in 1998 with concerning the HIV/AIDS pandemic. Revised Guideline 6 provides that

“States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of quality prevention measures and services, adequate HIV

246 Ibid.
prevention and care information, and safe and effective medication at affordable price.”

Thus, the absence of a national health policy for the prevention and treatment of HIV/AIDS or any other infectious diseases, such as tuberculosis in relevant countries where such diseases are prevalent, will constitute a violation of the obligation to fulfill the right to health. Similarly, in June 2001, a United Nations Declaration of Commitment was adopted at the United Nations General Assembly Special Session dedicated to HIV/AIDS. While the Declaration is not a legally binding treaty, it represents a symbolic statement concerning what governments have agreed should be done to combat the pandemic. This is not just at the national level but also in cooperation with the international society; and that they have committed to do so, with specific deadlines.

The Economic, Social and Cultural Rights Committee, which has closely examined the obligation to fulfill the right to health, also states that the obligation includes:

“[ensuring] provision of health care, including immunization programmes against the major infectious diseases, and ensure equal access for all to the underlying determinants of health, such as nutritiously safe food and

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potable drinking water, basic sanitation and adequate housing and living conditions.”

As explained above, the history of the development of health as a right does not mean only health care, but also involves public health matters such as sanitation and sewage systems. Thus, the obligation encompasses a wide-range of responsibilities. For instance, States have to ensure that the water system is accessible to the public, and that structural health services are provided. People living in remote and rural areas should have satisfactory access to basic health services. Violation occurs when States allocate the majority of their health fund to urban hospitals but neglect to provide some form of rural health centres for the people in remote areas. Hence, unbalanced geographical distribution of health services infringes the commitment to fulfill the right to health.

In Resolution 2005/23, the Commission on Human Rights reaffirmed the UDHR and ICESCR, and called upon States to pursue policies in accordance to international law, which would promote:

“6. (b) The accessibility and affordability for all without discrimination, including the most vulnerable or socially disadvantaged groups of the population, as well as infants and children, of pharmaceutical products or medical technologies used to treat and/or prevent pandemics such as HIV/AIDS, tuberculosis, malaria or the most common opportunistic infections that accompany them; …

[And]


251 See Introductory Chapter about history of the development of health as a human right.
7. (a) to refrain from taking measures which would deny or limit equal access for all persons to preventive, curative or palliative pharmaceutical products or medical technologies, including microbicides and male and female condoms, used to treat and/or prevent pandemics such as HIV/AIDS, tuberculosis …”

Therefore, if a State fails to take adequate measures to prevent the spread of infectious diseases to vulnerable segments of society such as women and children or, when gender segregation prevents women from being seen by male doctors, while there was a shortage of female medical staff at the same time, these constitute a clear infringement of the obligation to fulfill. Consequently, to be consistent with obligations under international law, laws, policies and regulations should be drafted and interpreted with the objective of realising the right to health. Moreover, to realise the right to health, states must also adopt and implement a national public health strategy and plan of action, based on epidemiological evidence, which address the health concerns of the populations.

3. Mechanisms for Monitoring the Right to Health

The accountability of States parties for their legal commitments is monitored at the international level through the reporting process, which is a means of promoting the implementation of the obligations. The United Nations has established several forums to monitor the implementation of the right to health.

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The Committee of Economic, Social and Cultural Rights, under the aegis of the Economic and Social Council, is the body responsible for monitoring compliance of States parties’ obligations under the ICESCR. Article 16(1) states that:

“The States Parties to the present Covenant undertake to submit in conformity with this part of the Covenant reports on the measures which they have adopted and the progress made in achieving the observance of the rights recognized herein.”

Hence, under Articles 16 and 17 of the Covenant, States parties undertake to submit periodic reports to the Committee within two years of the entry into force of the Covenant for a particular State party, and thereafter once every five years. The report must outline the legislative, judicial, policy and other measures taken to ensure the enjoyment of the rights contained in the Covenant, as well as the problems encountered in the process.

The reporting process is formal. The States parties submit the report and the Secretariat processes and translates it before it is reviewed by the Committee's five-person pre-sessional working group, which meets six months prior to a report being considered by the full Committee. The pre-sessional working group is entrusted with the task of preliminary consideration of the report, appointing one member to give particular consideration to each report, and developing written lists of questions based on disparities.

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256 Ibid.
found in the reports, which are then submitted to the States parties concerned and written replies requested.\textsuperscript{257}

When the Committee comes to consider the report in plenary, a representative of the reporting States is invited to present the report and address the pre-sessional working group’s written questions. Further questions will be put to the State representative who will endeavour to answer them as precisely as possible. At the end of the session, the Committee prepares a set of “Concluding Observations” regarding the status of the Covenant in that State. These are made public on the final day of the session. Concluding observations are split into five sections: (a) introduction; (b) positive aspects; (c) factors and difficulties impeding the implementation of the Covenant; (d) principal subjects of concern; (e) suggestions and recommendations.\textsuperscript{258}

States parties are provided by the Committee with detailed reporting guidelines, specifying the information needed to monitor compliance with their obligation to the right to health, to help them in preparing for the reporting process. There are two sections to the guidelines. The first, or general, part comprises a country profile dealing with matters such as information about the land and its people, the general political structure, the economic, social and cultural characteristics of the country and the general legal framework within which human rights are protected.\textsuperscript{259} The second part of the guidelines operates on an article by article basis, and provides a concrete example of what the Committee considers in determining the degree, and whether or not a government complies with its obligations for the right to health. Concerning the right to health, States

\textsuperscript{257} Ibid.
\textsuperscript{258} Ibid.
parties should focus on two issues, firstly the overall level of physical and mental health of the population, and secondly the degree of access to health care that is available to the population.\textsuperscript{260} Therefore, whether States parties have a national health policy and how committed they are to the WHO primary health care approach is considered. The guidelines emphasise on the provision of statistical information based on core indicators of health as defined by the WHO.\textsuperscript{261} Furthermore, the guidelines also indicate the importance of providing information about any groups whose health situation is significantly worse than that of the majority of the population.\textsuperscript{262} This is in line with the principle of non-discrimination, which is reiterated in most international human rights instruments.

Whether the monitoring system is effective or not is arguable. Fidler is of the view that the reporting system under the ICESCR does not represent an effective monitoring system because the ICESCR limits monitoring by not just relying on State reporting but also by limiting what the Committee and United Nations specialized agencies can do with the reports.\textsuperscript{263} Article 16(2) (a) states that the Committee is authorized only to receive State reports for consideration,\textsuperscript{264} but it does not have the power to make binding decisions on States parties after considering the reports.\textsuperscript{265} It can be inferred that the monitoring system does not have ‘teeth’ to fully enforce the obligations. Thus, the effect

\textsuperscript{260} Ibid, 138-142.
\textsuperscript{261} Ibid. Examples includes infant mortality rate, population access to safe water and adequate excrete disposal facilities, infant immunization and life expectancy.
\textsuperscript{262} Ibid.
\textsuperscript{265} Ibid.
of the reporting system is lost when States parties are not under strict commitments to comply with the obligations in accordance with the Covenant.

The reporting system and the guidelines provided by the Committee may be useful in its inception, however it is also subject to their reliance on the cooperation of States, not only in the submission of reports but also in their participation in the constructive dialogue.\textsuperscript{266} The unwillingness of States parties to cooperate may diminish the effectiveness of the reporting system of the ICESCR. While States may eventually submit their reports after some form of concessions by the Committee, it weakens the effectiveness of the idea of a constructive dialogue, the nature and purpose of which depends on positive input from the State party itself.

The Committee also runs the risk of being bogged down by backlog because States parties are often late in submitting their reports. The Committee’s response to this is to alert States parties whose reports are long overdue of its intention to consider these reports at specified future sessions. If no report is forthcoming, the Committee then proceeds to consider the status of economic, social and cultural rights in the States concerned in the light of all available information.\textsuperscript{267} This clearly runs counter to the idea that the reporting system was set up to safeguard against infringement of States parties’ obligations under the ICESCR.

On the other hand, rather than being seen as a chore or a formality, the reporting mechanism also serves a number of important functions. Among these are the initial


review function, the monitoring function, the policy formulation function, the public scrutiny function, the evaluation function, the function of acknowledging problems and the information-exchange function.\textsuperscript{268} The reporting mechanism should not be perceived as a remote episode of using precious bureaucratic resources just to meet the requirements of an international treaty.\textsuperscript{269} It is an important part of a continuing process designed to endorse and enhance respect for human rights as it is a chance to reaffirm a government’s commitments to respect the human rights of its people, and to proclaim to the international community that the government is serious about its international dedication to human rights.\textsuperscript{270} While this may be dismissed as mere ideals, however, ideals may be a motivating influence to guide the actions of State parties to meet their obligations under international human rights.

While Concluding Observations may not be legally binding, the fact that they are indicative of the opinion of the only expert body entrusted with and capable of making such pronouncements may carry some weight. Therefore, if States parties ignore or fail to act on such views, it will reflect their bad faith in implementing their ICESCR obligations and responsibilities. At the same time, it gives the country a bad name on the international stage. This may consequently encourage States parties to initiate necessary changes in policy, practice and law in response to the Committee’s Concluding Observations.

Therefore, despite the criticism against the monitoring mechanism of the right to health, it should be recognized that the reporting system as provided under the ICESCR is widely

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{269} \textit{Ibid.}, 20.
\item \textsuperscript{270} \textit{Ibid.}
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recognized and used to evaluate compliance with economic, social and cultural rights. In the absence of further alternatives to this reporting mechanism, it should be given more credit as a means to oversee the implementation of the rights, particularly the right to health.

4. Case Law

In this section, analysis is made of the available case law in which the right to health has played a part.

4.1 The Right to Life

The right to life is the most fundamental human right of all; but it is worth reiterating that it cannot be separated from the basic rights to food, shelter and the conditions to good health. The right to life cannot be interpreted narrowly as a liberty that only requires restraint by the States; but the protection of this right also entail States to “adopt positive measures as well.” Accordingly, States parties have to take all possible measures to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics. Domestic courts are also increasingly interpreting the right to health expansively. For instance, the Supreme Court of India held in the Frances Coralie Mullen case, that the right to life includes “the right to live with human dignity [as well as] the bare necessities of life, [such as] adequate nutrition,

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273 Ibid.
clothing and shelter.”

Hence, by broadly interpreting the right to life to include conditions that promote life with dignity as well as the minimum content of the right to health, it shows the indivisibility between civil and political, and economic, social and cultural rights; and that there is a right to health.

The link between the right to life and the right to health can be seen in the case of *Jorge Odir Miranda Cortez Et Al. v. El Salvador*,

concerning the provision of triple therapy drugs for HIV/AIDS. The El Salvador government’s failure to provide the drugs that prevent death and improve the quality of life of HIV/AIDS carriers violated the right to life, health and well-being of the victims of the case.

Concerning the right to health, the petitioners stated that the “immediate legal obligation” which can be deduced from the international instruments,

required that:

“The State should conduct all acts and omissions that are necessary to improve health, leading to the highest level of physical, mental, and social well being through the use of modern advances and scientific medical discoveries. The Salvadoran State cannot therefore fail to purchase and administer anti-retroviral treatments to persons living with HIV/AIDS for budgetary reasons if it did not seek and implement, some time earlier,

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275 Ibid.


277 These include their rights to life (Article 4), freedom from inhumane treatment (Article 5), equal protection (Article 24), judicial protection (Article 25) and economic, social and cultural rights (Article 26) provided in the American Convention on Human Rights. They also alleged that it was a violation of the right to health guaranteed by Article 10 of the Protocol of San Salvador.

278 Refer to instruments mentioned, *ibid.*
reasonable financial adjustments to permit their purchase and administration.”

This reflects discussions in this thesis of the legal obligations arising for States parties upon the ratification of the right to health in international human rights treaties. The Inter-American Commission of Human Rights (IACHR) declared the case admissible and concluded that although it is not competent to determine violations of Article 10 of the Protocol of San Salvador, the IACHR will consider the provisions related to the right to health in its analysis of the merits of the case, pursuant to the provisions of Articles 26 and 29 of the American Convention. This case is significant in that it challenges the dichotomy between positive and negative rights and the claim that because the right to life, being the basic of all universal human rights, is a negative right, it ranks above positive rights, such as the right to health. The rights connected to life and dignity should be accompanied by equivalent improvement in the standard of living of the people, particularly through economic, social and cultural rights, and equitable access to essential and life-saving medicine or health care clearly falls within the ambit of States obligations with respect the right to life. As expressed by the case’s petition,

“The right to life encompasses much more than not dying as a result of action or negligence attributable to the State, in accordance with the rules of international law. The right to life, in that broader sense, presupposes, \textit{inter alia}, that a person lives under conditions that are conducive to his well being.”


\footnote{Ibid.}

\footnote{Ibid.}
In some countries, the domestic courts have used the fundamental and constitutional right to life provision to order States to provide social services. This implies that courts have realised that the right to life is meaningless unless supported by the guarantee of certain social rights that make the chance to live with dignity equally obtainable.

Similarly, the Supreme Court of Venezuela, in *Glenda Lopez v Instituto Venezolano de Seguros Sociales*, rejected the appeal of the legal guardian of the Venezuelan Institute of Social Security (VISS); and held that failure of the institution to provide anti-retroviral drugs to HIV/AIDS sufferers on a regular and continuous basis violated the right to health and threatened the constitutional right to life of the victims. According to the court,

“The right to health as an integral part of the right to life has been enshrined in the Constitution as a fundamental social right (and not as mere ‘determinations for state’), whose satisfaction falls primarily the State, whose bodies work [towards the satisfaction] of the (progressive) elevation of the quality of life of citizens and, ultimately, the collective welfare.”

Indeed, Article 86 of the Constitution of the Bolivarian Republic of Venezuela provides that:

“All persons are entitled to Social Security as a nonprofit public service to guarantee health and protection in contingencies of maternity, fatherhood, illness, invalidity, catastrophic illness, disability, special needs, occupational risks, loss of employment, unemployment, old age,

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widowhood, loss of parents, housing, burdens deriving from family life, and any other social welfare circumstances. The State has the obligation and responsibility of ensuring the efficacy of this right, creating a universal and complete Social Security system, with joint, unitary, efficient and participatory financing from direct and indirect contributions. The lack of ability to contribute shall not be ground for excluding persons from protection by the system…**284

Accordingly, the VISS was created under the Social Security Act 1991 to fulfill these functions. Furthermore, the right to health has been recognized to encompass more than the mere provision of physical care for an individual's disease, but also adequate protection, *inter alia*, of their personal integrity, as well as of their broader mental, social, and environmental health. This again illustrates the role the right to health plays in the deliberations of domestic courts.

The Supreme Court also extended the effect of this decision to a wider audience, such as those who are registered with the VISS, those who have been diagnosed with HIV/AIDS, those who comply with legal requirements for getting the benefits of the social security system, as well as those who have requested the VISS for delivery of the drug treatment.285 The significance of this means that anyone who falls within the previously mentioned groups or categories can cite the decision without resorting to the courts. This also enhances the role of the courts in protecting the health and welfare of the people,

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which indirectly acknowledge the importance of the human right to health under international human rights law.

In *Paschim Banga Khet Mazdoor Sanity and others v. State of West Bengal*\(^ {286}\), the Indian Supreme Court addressed the constitutional duty of government-owned hospitals to provide emergency medical treatment to someone who was seriously ill. The plaintiff suffered serious head injuries and brain haemorrhage after falling off a train. He was turned away by various hospitals because the hospitals had inadequate medical facilities or did not have a vacant bed to accommodate him. Consequently, he had to seek treatment at a private hospital and incurred costly expenditure for it.

The Court held that the provision of adequate medical facilities of the people is an essential part of the obligations undertaken by the Government in a welfare state and this obligation is discharged by running hospitals and health centres that provides medical care to the person to avail those facilities.\(^ {287}\) Article 21 of the Indian Constitution imposes an obligation on the State to safeguard the right to life of every person; therefore, denial of timely medical treatment necessary to a person in need of such treatment would constitute a direct violation of this right. The Court recognized that financial resources are needed for providing these facilities, but the State could not avoid its constitutional obligation based on financial constraints. Accordingly, the State was ordered to compensate the Plaintiff for the loss suffered.

This case illustrates the innovation used by courts in dealing with the different areas of economic and social rights. By explaining the right to health as forming an integral part


\(^{287}\) *Ibid.*
of the right to life, the Court was able to provide substantive protection to the right to health as well as to show the indivisibility of civil/political and economic/social/cultural rights.

4.2 General Evaluation

Strictly speaking, in the above-mentioned judgments, judicial actions were not taken based on the right to health. Still, it is obvious that the right to health plays a vital role in the deliberations of the courts. The fundamental right to life is the basis of all rights, and the expansion of the scope and content of the fundamental right to life as encompassing the bare necessities of life such as adequate nutrition, clothing and shelter supports the contention that there are basic rights without which no other rights can be enjoyed. Hence, the expanded notion of the right to life allowed the court to overcome objections on grounds of justiciability to its adjudication of the enforceability of economic, social and cultural rights.\textsuperscript{288}

Moreover, the right to life is not subjected to the principle of progressive realization under international law. This means that the right can be brought into play to emphasize the urgency of taking immediate actions to implement the right to health. The right to life, being the fundamental human right it is, is generally enshrined in the constitutions of almost all countries. Therefore, arguing for a right to health via the ambit of the right to life can be an important breakthrough to endorse such economic, social and cultural human rights further and to increase the judicial dimensions to the right to health.

5. Other Implementation of the Right to Health through Case Law

The right to health has been recognized in many international as well as regional treaties and the majority of the world’s governments are obliged through these treaties or national constitutions, or both, to respect, protect and fulfill the human right to health. However, the common perception is that in most cases, the right to health is unlikely to be an enforceable legal right. Still, while many domestic courts have traditionally been more comfortable with dealing with violations of the negative duties imposed by economic, social and cultural rights, the number of case law on the positive responsibilities regarding the right to health is slowly developing and increasing. In a number of under-developed and developing countries - first in Latin America, later in Africa and Asia, national courts have granted access to medical treatments. These decisions have important implication for how health sector resources are prioritized and allocated as well as challenge policy-makers and administrators to take this right more seriously. Hence, an analysis of the manner and the extent to which the right to health is dealt with by the domestic courts, be it on the basis of international treaty provisions or national laws, will now be discussed.

5.1 Latin America

In Vicentonti v. Ministry of Health and Social Welfare, a case concerning the protection of the right to health of people living in areas affected by hemorrhagic fever, the Argentinean Federal Court of Appeals found that any individual could bring complaints

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289 See Section 3 of Chapter One pp. 31-39.
concerning the right to health. This is because international treaties referring to the right are incorporated and the Constitution should be construed as consistently as possible with the objectives of social justice and promotion of the general welfare as set in its preamble.\(^{291}\) It was held that the government was legally obliged to intervene to provide health care when the health of individuals could not be guaranteed either by themselves or the private sector.\(^{292}\) Consequently, the State was ordered to manufacture the vaccine and to comply immediately with the schedule that had already been designed for such purposes by the Ministry of Health. Thus, the significance of the case lies in its recognition of international human rights treaties on health and the confirmation of government’s positive obligations to provide health care.

In *Mendoza & Ors v. Minister of Public Health and the Director of the HIV-AIDS National Programme*\(^{293}\), the applicants (who were living with HIV/AIDS) were forced to abandon the required triple-therapy. This was because the action of the public hospital to reduce the therapy to only one of the three drugs was potentially more harmful than not taking any of the drugs at all (if the drugs are not used in the appropriate combination, the patients may develop drug resistance and gain no therapeutic benefit instead). An *amparo* writ was filed against the defendants, demanding the immediate restitution of the provisions and that the government conducts various necessary medical tests to update


their medical prescriptions. The plaintiffs also alleged violations of their constitutional right to health as well as the constitutional guarantee that public health programmes, services and actions be provided free of charge.\textsuperscript{294} The Court ordered that the State of Ecuador must ensure the right to health of its people, and found that the Ministry of Public Health had committed an omission in failing to meet its responsibility to provide an immediate, diligent solution, which significantly harmed the conditions of life of those living with HIV/AIDS. This amounted to a violation of rights. These included positive social rights – immediately enforceable legal rights that are binding upon the authorities, which have corresponding legal obligations.\textsuperscript{295} Accordingly, the Court concluded that the right to health was an economic right, directly enforceable by the plaintiffs and thus, the Ministry’s omission violated the plaintiffs’ fundamental rights to life and to health. This challenges the liberal consensus that only negative rights are enforceable human rights.

In the Venezuelan Court case of\textit{Cruz Bermudez et al v Ministerio de Sanidad y Asistencia Social}\textsuperscript{296}, action was taken by more than 170 people suffering from HIV/AIDS. They argued that the Ministry of Health and Social Welfare’s failure to provide the necessary anti-retroviral drugs violated their right to life, health liberty and security of the person, equality and benefits of science and technology. They requested the Courts to order the Ministry to, \textit{inter alia}, ensure the regular and periodic delivery of medicines, develop a policy of information, treatment and medical care for people living

\textsuperscript{294}\textit{Ibid.}

\textsuperscript{295}\textit{Ibid.}


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with HIV/AIDS, and to provide all medicines for the treatment of opportunistic diseases. However, the Ministry of Health and Social Security counter-argued that the accusations were unfounded, citing lack of financial resources and pointing out that in spite of this, it was still fulfilling its obligations towards the right to health by implementing a policy of prevention and care throughout the national territory.297

The Court dismissed the claims of the right to liberty, security of the person and equality, but focused on the right to health. The Court stated that the right to health, life and access to science and technology are closely linked, explaining that the right to access to benefits of science and technology would provide HIV/AIDS sufferers a guarantee of preserving the vital minimum conditions of the right to health. This would mean the chance to extend the life of these patients, as a possible long-term cure of the disease that afflicted them. The right to health was protected by Article 76 of the Venezuelan Constitution, and it was observed by the Court that in view of the financial constraints of the Ministry of Health, the failure to comply with the constitutional right to health was not strictly speaking a legally negligent conduct of the administration.

However, the Court held that there was a violation of the plaintiff’s right to health. This was because the Ministry failed to use the mechanisms available (to solve the budgetary issue) through Venezuelan law to request the President of the Republic for the resources it deemed necessary, in order to safeguard the right to health and life of people infected with HIV/AIDS.298 Accordingly, the Court ordered the Ministry to provide anti-retroviral necessary for treating opportunistic infections and diagnostic testing, free of charge for

297 *Ibid.* This included, *inter alia*, the review of prevention programmes aimed at young people and sex workers; re-editing of 5000 brochures about HIV/AIDS prevention to be distributed in the various regions; distribution of 100,000 condoms as required by the Regional Health Coordination, NGOs and Public Institutions; and a National Campaign on protected sex, of which the whole plan would amounted to one hundred eighty million bolívares.

all Venezuelan citizens and residents. The Ministry was also ordered to ask the President of Venezuela to correct the budgetary allocation known as “Activity: AIDS Prevention and Control” or to provide additional expenditure for the remaining fiscal year, and to ensure future budget bills include enough resources for this purpose.\textsuperscript{299} Torres is cautious of the significance of this decision, stating that although procedurally this case was important for international law (because it represents another example of the vital role NGOs play with promoting the human right to health), in reality, health as a human right has not penetrated Venezuelan political and popular culture and that the government has done little to improve the access of medications to people living with the virus.\textsuperscript{300} Nonetheless, this case illustrated how the principle of progressive realization cannot potentially be misused as an excuse to justify a government’s failure to provide the necessary health care or services.\textsuperscript{301} Although the decision did not extend its effects to all those affected by HIV/AIDS except the plaintiffs, it shows the possibility of filling multiple individual actions to achieve amendment in a given health policy of general scope.\textsuperscript{302}

5.2 Philippines

Case law discussed thus far usually focus on the pandemic of HIV/AIDS and access to the necessary anti-retroviral drugs and for other diseases. There are also environmental-

\textsuperscript{299} Ibid.


\textsuperscript{302} Common interest was later acknowledged in \textit{Glenda Lopez v Instituto Venezolano de Seguros Sociales}, where a group of HIV/AIDS patients were recognized as representatives of all people suffering from the virus. See, \textit{Glenda Lopez v Instituto Venezolano de Seguros Sociales}, (2002) Case No. 00-1343, Decision No. 487, \texttt{http://www.tsj.gov.ve/decisiones/scon/Diciembre/3013-021202-02-0481.html}, accessed 5 October 2007.
related cases where the right to health was considered justiciable.\textsuperscript{303} In the Philippines case of \textit{Minors Oposa v. Secretary of the Department of Environmental and Natural Resources (DENR)}\textsuperscript{304}, an action was filed by several minors represented by their parents to have logging licenses revoked in the country. This was because the extensive logging caused deforestation and damaged the environment of which the adverse effects to the “plaintiff minors’ generation and to generations yet unborn are evident and incontrovertible.”\textsuperscript{305} It was claimed that these actions violated their constitutional rights to a “balanced and healthful ecology”\textsuperscript{306} and to health.\textsuperscript{307} The Court found that a \textit{prima facie} case had been made for infringement of the constitutional provisions on health and the environment and reversed the dismissal of the claim by the trial court. The decision was noteworthy because the Court found that the petitioners had locus standi to file a class suit of this nature for others of their generations and succeeding generations, on the basis of inter-generational responsibility.

Interestingly, the concurring opinion of Feliciano J seemed to invoke a common argument regarding general constitutional provisions (as well as those in international

\begin{footnotes}
\item\textsuperscript{303} See, \textit{Yanomami Indians v. Brasil}, (1984) Inter-American Commission on Human Rights, Case 7615: the Brazilian government was found to have violated the right to the preservation of health and well-being enshrined in the American Declaration of the Rights and Duties of Man, by failing to protect the Yanomami Indians from disease and ill-health as well as their heritage following their forced displacement; \textit{Menores Comunidad Paimeni s/acción de amparo}, Cámara de Apelaciones en lo Civil de Neuquén, Sala II. Exp. 311 CA-1997: Court concluded that the provincial State arbitrarily failed to protect the right to health of indigenous children and youth who were exposed to water contaminated with lead and water.


\item\textsuperscript{305} Ibid.

\item\textsuperscript{306} Section 16, Article II of the 1987 Constitution states that “The State shall protect and advance the right of the people to a balanced and healthful ecology in accord with the rhythm and harmony of nature.”

\item\textsuperscript{307} Section 15, Article II of the 1987 Constitution provides that “The State shall protect and promote the right to health of the people and instill health consciousness among them.”
\end{footnotes}
treaties) concerning economic and social rights that is, that they are not susceptible to application in a court of law; hence, they are not justiciable rights.\textsuperscript{308} He stated that the petitioners and the Court had failed to identify the particular provisions which could give rise to a specific legal right and that the language of the constitutional provisions was too general. Accordingly, if such general constitutional provisions were to be combined with “remedial standards as broad-ranging as a grave abuse amounting to lack or access of jurisdiction, the result would be to propel courts into the uncharted ocean of social and economic policy making.”\textsuperscript{309}

5.3 General Evaluation:

A number of court decisions in different countries were discussed, exploring the possibility of implementing the international or constitutional right to health through domestic judicial systems. Compared to other human rights especially civil and political rights, courts are generally more reluctant to found their decisions just on the basis of the right to health. Although the ratio for the number of judgments where the right to health is justiciable is considerably less, there is increasing recognition of the right to health and the role governments have in protecting the right of health of their people.

6. Concluding Summary

A recurring theme throughout the present thesis is that the human right to health is a recognized human right enshrined in numerous international human rights documents. This chapter considered further the development of the right to health.


The right to health is subject to progressive realization and it is recognized that not all countries have the immediate and necessary resources to fully implement the right to health of all their people. Still, budgetary reasons should not be used as excuses by governments to avoid spending on health. Given the importance of health, governments have to prioritize resources in order to make sure that necessary resources are channeled into promoting access to better health care. This does not mean that issue of allocation of resources does not exist and that all possible medical treatment should be provided free to the people. Governments have to weigh the situation and develop reasonable policies to implement the right to health. For example, in a country with a high prevalence of preventable diseases and deaths (such as HIV/AIDS cholera, and tuberculosis), the health of the people is a central issue the government of the country needs to address. This also implies that the health sector is falling short of its obligations under the international treaties. Accordingly, the government would need to rectify the problem with relevant health policies and to fulfill its responsibilities to implement the right to health (in a progressive manner). Thus, it is not the intention of the treaty clause to act as reason for State parties to avoid their responsibilities under the treaty. State parties must still take constructive and tangible steps towards the realization of the right to health.

Having identified and explained in detail the tripartite obligations of State parties – to respect, protect and fulfill – a better understanding is garnered of how governments are accountable to their people in realising their human right to health upon the signing of human rights treaties endorsing the right to health.
Toebes is of the view that the justiciability of the tripartite obligations depends on “the extent to which the right created provides programmatic obligations for States”.310 ‘Programmatic’ in this sense means that governments will have to take a more pro-active approach to implementing the right to health and that positive actions are required. As argued by the liberal camp in Chapter One, the fact that economic, social and cultural rights require States to intervene with positive programmes in order to realise the human rights makes them untenable and impractical. Hence, they are less likely to be considered justiciable by the courts. Accordingly, the more negative the character of the obligations, the more likely for them to be found justiciable by the courts.

A simple analysis will deduce that out of the three obligations to respect, to protect and to fulfill the right to health, the obligation to respect is the most negative in character, while the obligations to protect and to fulfill are more positive in nature. In respecting the right to health, the State parties are prevented from doing activities that will limit or obstruct equal access to health facilities as well as other actions that may harm the health of the people. It is arguable that courts are more likely to find this obligation justiciable because it is much more specific in nature and it avoids the criticism that courts should cross the line beyond their judicial role and that it is not their duty to make health laws or policies. Conversely, the obligations to protect and to fulfill the right to health have a programmatic nature to them, which requires States parties to embark on positive actions that are often long-term and need extensive expenditure. Consequently, they are less likely to be enforceable in law.

Even though the number of court cases on the right to health is not extensive, it is worth noting that courts, especially in the developing countries, are increasingly willing to found their decisions on the internationally recognized human right to health. Interestingly, most of these court cases are from the developing countries, and it should be qualified here that the exact number of cases where the right to health has played a role is unknown due to the fact that many of the judicial decisions and judgments are set in languages other than English.

It is questionable whether the practice of trying to categorize the obligations of State parties into negative - thus justiciable, and positive, – will assist. The demarcation line is a thin one as all the obligations overlap to some extent. In theory, the right to health protects the right to have access to health care and protects the people from being subjected to health-harming activities. However, the question remains as to whether or not there are ‘health sanctuaries’ in the globalized world. Thus, what is more important is to see the issue from a more objective perspective and trying to understand the reasons as to why the right to health is not fully implemented in reality.
Chapter Three: Global Social Realities and Stark Disparities – Managing Health Under Globalization

Introduction

“Never have so many had such broad and advanced access to healthcare. But never have so many been denied access to health. The developing world carries 90 percent of the disease burden, yet poorer countries have access to only 10 percent of the resources that go to health.”

In the previous chapter, the principle of ‘progressive realization’ was discussed to help define the right to health. The responsibilities of States Parties as well as the monitoring mechanisms of the right to health, were considered in order to understand how this human right can be implemented. Through consideration of the case law in the developing countries, it is possible to conclude that the human right to health is an enforceable human right and is increasingly being recognized internationally.

However, in order to identify why its realization is complicated, it is necessary to analyze this human right in the context of globalization. Globalization is a worldwide phenomenon that has the influence to change the operation and implementation of human rights. This chapter begins with the premise that we cannot understand the linkages between globalization and health until we have looked carefully at the concepts surrounding this fascinating topic.

Is it possible to only study human rights – specifically the right to health, in isolation? It is questionable whether this is really possible or even advisable, given the fact that it is in many ways related to the politics and social workings of the 21st century. Law is not a

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science; it is a normative ideology and thus tightly tied to the notion of power. As Farmer puts it,

“As the West intervenes ever more frequently but ever more inconsistently in the affairs of other societies, the legitimacy of its rights standards is put into question. Human rights is increasingly seen as the language of a moral imperialism just as ruthless and just as self-deceived as the colonial hubris of yesteryears…”

Hence, this chapter discusses how the structure and current rules of today’s market-led economic globalization widen the chasm between the privileged and the destitute. Consequently, it imperils the health and lives of the world’s poor (and therefore their human right to health). Therefore, the issue of poverty will be discussed.

The scholarly and policy debates surrounding globalization have been abundant and wide-ranging in approach and conclusions. It is the purpose of this chapter to address the causal links between globalization and the human right to health. This chapter begins by looking at the statistics which illustrate the disparities between the rich and poor of the world and how human health has progressed thus far in history.

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1. A Brief Inroad into Statistical Realities

Despite the prevalent rhetoric of health and human rights, the world is much more complex than international instruments assume. It is a world of inequality and there are numerous political and economic forces that maintain that inequality.

The cost of achieving and maintaining universal access to basic education, basic health care, adequate food, and safe water and sanitation for all has been estimated at less than 4% of the combined wealth of the 225 richest people in the world. However, in stark realities, the scenario in many parts of the world, especially developing countries, are far from it. Diseases proliferate in communities lacking adequate housing, food, sewage, waste disposal, and clean water for drinking, cooking and washing. With such basic needs unmet, members of those communities are vulnerable and more susceptible to the spread of air- and water-borne diseases such as Tuberculosis (TB), typhoid, malaria and cholera.

However, many people, being more concerned about illnesses connected to urban lifestyles, such as obesity or cardiovascular sickness, believe that such living conditions and diseases are uncommon today. We now have the technological means to eradicate nutritional deficiencies and infectious diseases. The WHO’s 1998 annual report, commemorating the organization’s fiftieth anniversary, celebrated the many health successes of the last half century, including:

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314 Statistics from the year 1998 are used in this part of Chapter Three as 1998 marked the 50th anniversary of the World Health Organization as well as the UDHR (1998 is also close to the end of the 20th century), and to serve as comparison with health information from the 21st century used as illustrations in current chapter.
(a) Average worldwide life expectancy increased from 48 years in 1955 to 66 years in 1998.\textsuperscript{315}

(b) 210 of every 1000 babies born in 1955 died before their fifth birthday – a total of 20.6 million deaths in that year. By 1995 the death rate had fallen to 78 per 1000 (10.6 million deaths) and should decline further to 37 per 1000 by 2025, when it is projected that the total deaths will be 5.1 million.\textsuperscript{316}

(c) In 1948, immunization programmes were largely confined to industrialized countries, and even then were often partially implemented. From 1981 there was a fourfold increase from approximately 20\% to reach the 1990 goal of 80\% immunization coverage among infants worldwide with BCG, measles, and the third dose of DPT (diphtheria, pertussis, tetanus) and oral polio-virus vaccines. By 1995, over 80\% of the world’s children had been immunized against diphtheria, tetanus, whooping cough, poliomyelitis, measles and tuberculosis.\textsuperscript{317}

Such research findings, which are disseminated widely, demonstrate the gains and progresses of aspects of human health globally. However, it is worth noting that obtaining accurate data remains a key challenge. The Human Security Report 2005 has an interesting quote with regards to the difficulties of data collection:

“When it comes to statistics … numbers take on a life of their own, gaining acceptance through repetition, often with little enquiry into their

\footnotesize{\textsuperscript{316} Ibid, 61.}
\footnotesize{\textsuperscript{317} Ibid, 64.}
derivations. Journalists, bowing to the pressures of editors, demand numbers, any number. Organizations feel compelled to supply them, lending false precision and spurious authority to many reports. It is acknowledged that data on economic growth and its relationship to standard of living remain difficult to interpret for sub-national and transnational populations because of the form of available data and how they are processed. Still, data that will be used in this thesis provides reasons for the widespread concern over the social impacts of globalization.

Closer examination shows that signs of dramatic improvements in international health are misleading in important respects. Gains in some areas are counterbalanced by stagnation and decline in others. Life expectancy at birth varies from 82 years in Japan to 40.5 years in Zambia. There is a big difference in infant mortality rates between Organization for Economic Co-operation and Development (OECD) countries and the developing world. For example, Luxembourg’s infant mortality rate improved from 19 in 1970 to 4 in 2005, whereas in Sierra Leone, the infant mortality rate has gone through a relatively modest reduction, from 206 in 1970 to 165 in 2005. Based on these statistics, countries in Sub-Saharan Africa have a long way to go before their progress rates are as high as countries in the developed world.

321 The OECD consists of 30 member countries that are committed to democracy and principles of free market economy. Members include the United States, United Kingdom, Japan, Canada and numerous European countries.
Aggregate statistics tend to conceal the fact that health improvements are unevenly distributed and many of the significant health gains in the past half century are marred by the growing health disparities between the world’s wealthy and the world’s poor. According to the WHO, only 1% of maternal deaths occur in high-income countries: a woman’s lifetime risk of dying from complications in childbirth or pregnancy is about 1 in 7 in Niger and 1 in 48,000 in Ireland.\textsuperscript{323} One aim of the Millennium Development Goals is to decrease the maternal mortality rate by 75% between 1990 and 2015. However, progress has been slow with only 5% reduction (from 430 to 400 maternal deaths per 100,000 live births) in global maternal mortality ratio by 2005 and no development has been made in Sub-Saharan Africa (where the risk of such death is the highest).\textsuperscript{324} Hence, these figures on the state of maternal health further reflect the significant gap between the rich and the poor.

As the WHO reported, “inequities in how society is organized mean that the freedom to lead a flourishing life and to enjoy good health is unequally distributed between and within societies.”\textsuperscript{325} While the overall life expectancy in the world has improved over the last half century, people are still suffering from the burdens of diseases and ill health (especially prominent is the pandemic of AIDS and the re-occurrence of tuberculosis). This was exacerbated in part by externally imposed economic programmes that intensify the effects of poverty. Thus, the relationship between poverty and health is discussed in the next section.

\textsuperscript{325} \textit{Ibid.}

2. Poverty and Development as a Public Health Issue: Conventional Wisdoms and Complex Realities

‘I became sick because of my poverty.’ ‘Well, I became poor because of my sickness.’ The two-way relationship between poverty and ill-health affects billions. \(^{326}\)

Poverty is the biggest epidemic that the global public health community faces. Poverty is best described as being in a state where there is a lack of economic resources, lack of access to education, lack of access to basic necessities such as food, water and sanitation. This global phenomenon underlies most cases of under-nutrition and diseases, and deepens vulnerability to the effects of illness and trauma. Poor countries are unable to give their health and social services adequate resources resulting in a deficiency of health systems that compounds poverty at the household and community levels. \(^{327}\)

Almost everyone has a vague understanding of what ‘poverty’ and ‘global inequality’ means. But how is this reflected in quantitative measures? Everyday, more than 800 million people go hungry (of which 300 million are children – more than 90% of which suffer from long-term malnourishment and micro-nutrient deficiency). \(^{328}\) Of the 4.4 billion people in developing countries, nearly three-fifths lack basic sanitation, almost a third (more than 1 billion people) do not have access to safe sources of clean water, a quarter of these 4.4 billion people lack adequate housing and one-fifth of the people in the least developed countries, mostly in Sub-Saharan Africa, live beyond means of


\(^{327}\) *Ibid.*

modern health services.\textsuperscript{329} 5 million people, mostly children, die each year from water-borne diseases.\textsuperscript{330}

On the other hand, as has been shown in numerous United Nations’ documents\textsuperscript{331} and echoed by the protests of poor people throughout Latin America, Asia, Africa, and increasingly in developed countries, it is pointed out that under conditions of corporate globalization, world poverty and the gaps between the rich and the poor both within and among countries continue to rise. According to the UNDP report 1998 (a widely quoted report),

“The 15 richest people in the world enjoy a combined asset that exceeds the total annual GDP of all sub-Saharan Africa. At the end of the 1990s, the wealth of the three richest individuals on earth surpassed the combined annual GDP of the 48 least developed countries”.\textsuperscript{332}

Although inequality is commonly described in terms of differences between rich and poor countries, one fifth of the richest people in the world come from developing countries.\textsuperscript{333} Similarly, poverty and widening disparities are not confined to poor countries – inequalities have risen in wealthy nations over the past two decades.

The World Bank has set the benchmark for absolute poverty\textsuperscript{334} at US$1 dollar per day, as measured by relative purchasing power parity. Using this poverty line, the World Bank estimated in 2004 that some 985 million people are absolutely poor.\textsuperscript{335} Most recently, the World Bank has revised the international poverty line to US$1.25 dollars (in 2005 prices\textsuperscript{336}). New data collected indicated that 1.4 billion people are still poor by the standards of the poorest countries and that 400 million more people lived below the poverty line than earlier thought.\textsuperscript{337} Nonetheless, critics argue that the World Bank’s methodology for measuring poverty is flawed and underestimates the severity of poverty.\textsuperscript{338} If the poverty line has been set at US$2 dollars a day, the figure would exceed 3 billion.

Statistics show that there has been some progress for the poor, albeit unevenly across regions. East Asia has improved from being the region with the highest incidence of poverty in the world with almost 80\% living below US1.25 dollars a day in 1981 to 18\%

\textsuperscript{334} Absolute poverty was defined as “a condition characterised by severe deprivation of basic human needs, including food, safe drinking water, sanitation facilities, health, shelter, education and information. It depends not only on income but also on access to services”, quoted in Gordon, David, ‘Indicators of Poverty and Hunger’, (2005) http://www.un.org/esa/socdev/unyin/documents/ydiDavidGordon_poverty.pdf, accessed 5 May 2008.


\textsuperscript{336} The revision was made based on a global statistical initiative called the International Comparison Program. It is beyond the purpose of this thesis to go in depth into poverty measurements. To read more, see World Bank, ‘International Comparison Program 2005’, http://siteresources.worldbank.org/ICPINT/Resources/icp-final.pdf, accessed 5 September 2008.


in 2005.\textsuperscript{339} The poverty rate has also fallen over 1981-2005 in Latin America and the Caribbean, and in the Middle East and North Africa.\textsuperscript{340} Sub-Saharan Africa has shown no progress with the number of poor almost doubled over the same time period, from 200 million to 380 million.\textsuperscript{341} Such findings illustrate the magnitude of the issue of poverty, which may further complicate the people’s access to their right to health.

Like any other pressing social problem, attempts are made to downscale the magnitude of human suffering caused by poverty. In recent years, the consensus among politicians, economists and corporate figures is that poverty can only be significantly tackled through the benefits of long-term economic growth. As more and more countries enter into the realm of free market trade and economic policies and become more competitive in the capitalist global economy, and in the process make economic globalization and modernization their priorities, the inequalities between countries are expected to gradually diminish.\textsuperscript{342} The common theory is that with economic development, eventually wealth will trickle down to the masses and with that, the economic and social conditions of the people will be lifted up as well.

Some authors identified such claims as the conventional wisdom of our era.\textsuperscript{343} However, given the complexity and obscurity of the relationships between poverty, inequality and economic growth, such claims remain problematic. Laurie Wermuth is of the view that if the health problems of the poor are ignored, economic growth is likely to result in an


\textsuperscript{340} \textit{Ibid.}

\textsuperscript{341} \textit{Ibid.}


\textsuperscript{343} \textit{Ibid.}
even bigger divide between the health of the wealthy and the impoverished. She cites as an example the case of the Congo which is rich in natural resources. During Mobutu Sese Seko’s three and a half decades in power, his government arranged for United States and European’s corporations to mine precious metals and export them. Little economic development occurred, as Mobutu’s family and a small group of supporters got extremely rich while running an empty ‘shell’ government. This is an example of the unequal distribution of economic rewards as the citizens’ standards of living, education and health were left underfunded and underdeveloped.

What is clear from statistics and reports is that poverty kills. The WHO underscores that poverty signifies brutal suffering and premature death. Poverty is the main reason why babies are not vaccinated, clean water and sanitation are not provided, and curative drugs and other treatments remain unavailable. Around the world, poverty is the chief cause of reduced life expectancy, of handicap and disability, and of starvation. Countries with a prevalence of a high poverty rate tend to have very low Gross Domestic Product (GDP) or Gross Domestic Income (GDI). Poor countries, often lacking in resources, are unable to provide the necessary health care or services. Population’s health suffers as a result of no such access, which leads to an inability to work or to upgrade living standards. This compounds the problem of poverty, which again leads back to the causal nexus of poverty and health. The relevance of the poverty issue for the present thesis is that the implementation of the right to health is affected by problems resulting from poverty. The resulting chain reaction of situations further reveals the complexities of any possible

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345 Ibid.
implementation of a blanket human right to health. It also illustrates how a discussion on human rights and health cannot remain merely within theoretical realms, if it is to retain a realistic measure of practical utility.

In distributing wealth, economic structures both assign and respond to power. Within these structures, certain interests are privileged and resources are distributed for the benefit of some groups at the expense of others. All of these have harsh repercussions on the health of individuals, especially poor people. This is considered in Chapter Four, which discusses the roles of pharmaceutical providers and how they affect the exercise of a human right to health.347 It is arguable that political decisions can determine whether a poor country’s limited resources will be used to construct local clinics or will go instead to purchase new weapons for the military. The political dimension emerges again when poor countries cut funding for social services in order to make staggering payments on foreign debts. Hence, the relationship between health and the economy cannot be separated from questions of power – who wields it, how, and to what ends. This brings us to the next section which discusses the non-linear causal pathways that connects globalization and the right to health.

347 See section 4 and 5 of Chapter Four pp. 181 – 215.

“The current path of globalization must change. Too few share in its benefits. Too many have no voice in its design and no influence in its course” – World Commission on the Social Dimensions of Globalization, 2004

The link between health and globalization is far from new, although health concerns have been slower to enter the globalization debate than environmental, social or economic issues.\(^{348}\) Disease and pestilence have long followed trade routes from one part of the world to another.\(^{349}\) The economic costs associated with the 2003 outbreak of Severe Acute Respiratory Syndrome (SARS) had alerted many high-income countries to the value of global infection control. But the increased spread of communicable diseases or unhealthy consumption by trade vector is only a small part of the globalization/health relationship.\(^{350}\) Of far more importance is the interplay between globalization and health determinants such as poverty and inequality.

Rapid changes in our global economy can have profound effects on the health of millions. The causal pathways that link globalization with the illness or injury of particular individuals are often non-linear, involving multiple intervening variables and feedback loops, as illustrated by Chart 1. This section on globalization begins with a discussion on the meanings of globalization and concludes with the assertion that this thesis shall specifically focus on corporate or economic globalization. Thus, this sets the

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\(^{349}\) See Section 1 of Introductory chapter.

stage to further explore the relationship between this global phenomenon and the human right to health.

Chart 1: Causal Pathways between Globalization and The Human Right to Health

3.1 The Definitions of Globalization

There is none one agreed definition of globalization because the concept is inseparable from different value-based views of the way the world works and ought to work.\textsuperscript{352} There is no need to delve into a long-laboured discussion about the intricacies of the meaning of globalization, as this debate is well-documented elsewhere.\textsuperscript{353} However, as noted by Kelley Lee, globalization is about “changing the nature of how humans interact across three types of boundaries – spatial, temporal and cognitive”\textsuperscript{354} “It is [still] necessary to draw a line in the sand to show where we stand on a range of issues if we are to avoid falling victim to intellectual vagueness and imprecision”.\textsuperscript{355} Therefore, some definitions of globalization will be looked at and to link them to this Chapter as well as Chapter Four.

Globalization is generally understood as “the growing interdependence of countries worldwide through the increasing volume and variety of cross border transaction in goods and services and of international capital flows, and also through the more rapid and widespread diffusion of technology”.\textsuperscript{356} Together, these processes suggest that events, decisions and activities in one part of the world increasingly affect the economic, social and political well-being of individuals and communities in distant locations, as patterns


\textsuperscript{355} \textit{Ibid}, 4.

of interaction and interconnectedness achieve both greater density and intensity.\(^{357}\) Chart 1 illustrates the causal relationship between the main features of globalization and the health of the people (which directly or indirectly infringes the human right to health).

While there are many aspects of globalization, what is essentially of concern here is economic globalization or more specifically corporate globalization. Thus the discussion will concentrate on the institutional and economic determinants of Chart 1, while the environmental and social-cultural determinants will be considered more briefly.

Corporate globalization - as Madeley terms it,

“… is the integration of people and countries into a single global economic system where the corporations have huge power, and represents a transfer of wealth from the public to the private sector.”\(^{358}\)

This is especially apposite when one looks at the influences of pharmaceutical multinationals on access to medicines,\(^{359}\) as well as those of transnational corporations (which will be discussed in later sections of the current Chapter).

How the current world market system works is described by Tauli-Corpuz (a member of the International Forum of Globalization) who defines corporate globalization as:

“…. the process wherein former imperialist countries are ensuring their continued economic, cultural and political domination of the world through the creation of international laws on trade, finance and investment liberation. These international standards, laws, policies and programmes are made at the WTO, the World Bank, the IMF… The main goal of


\(^{359}\) Refer to Chapter Four of thesis.
globalization is to ensure the continuing access of OECD (industrialized) countries to the markets of the developing or underdeveloped countries and for those countries to still remain as suppliers of primary resources and consumers of surplus industrial and agricultural commodities from the north.360

This is relevant in the context of trade liberalization especially from the perspective of the developing world, and when one looks at how multilateral trade agreements, such as those covering intellectual property rights, appear more favourable for the developed countries than developing countries.

Globalization is not a new phenomenon.361 Its dynamics are as old as Marco Polo’s voyages.362 Since the 16th century, globalization has been developing gradually when the European countries started colonizing countries for trade purposes. Today, while the benefits of globalization are celebrated (such as access to knowledge, availability of a greater choice of foods and consumer goods and advances in medical science), these benefits are experienced unevenly and distributed differently, both across and within

362 Interestingly, Thomas Friedman in his book - The World is Flat: A Brief History of the Globalized World in the 21st Century, (2005) London: Allen Lane, suggests that there are three great eras of globalization. The first lasted from 1492 - when Columbus set sail, opening trade between Europe and the New World - until around 1800. It shrunk the world from size large to a size medium. The key agent of change, which is the dynamic force driving the process of global integration, was how much brawn, i.e. how much muscle, horsepower, wind power and steam power, your country can muster and how creatively you could utilize it. Globalization 2.0 lasted roughly from 1800 to 2000, interrupted by the Great Depression and two World Wars. The world shrunk from size medium to small, with the key agent of change being ‘Multinational companies’. Globalization 3.0 starts when we ushered in 2000, which shrinks the world from size small to a size tiny and flattening the playing field at the same time. The key agent of change being the new-found power for individuals to collaborate and compete globally.
societies. Statistics in the previous sections showed the widening gaps between the world’s richest and poorest in many aspects and it is arguable whether globalization could help improve the current disparities or aggravate them.

Proponents of globalization, in their drive to focus and centralize their control over the accumulation of wealth, are motivated to spread capitalism into every corner of the world, and obliterate all barriers in its way. This aspect of globalization is acknowledged by Luttwak in his analysis of the losers and winners of ‘turbo-capitalism’. He writes that nothing can be compared to the unique ability of capitalism to transform simple human greed into infinitely varied technologies.

However, traditional economies once guided by unchanging practices, communist economies directed by bureaucrats, and closed economies commanded by rulers have to gradually adjust to multilateral Capitalist economic practices. Since the 1990s, there has been growing opposition to projects and polices which are the products of corporate globalization. For example, privatization of water, electricity and healthcare systems; removal of subsidies for basic foods such as cooking oil, flour and milk; imposition of school fees; and salary cuts for teachers, nurses and doctor. To understand more about the causal pathways between globalization and health, the next section sets the stage to discuss the relationship between this global phenomenon and the human right to health.

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3.2 Causal Pathways between Globalization and Health

Globalization is an on-going process of local and regional realms integrating into a global phenomenon. For the relevance of this Chapter, Chart 1 illustrates the relationship between globalization and health and how this can influence the realization of the right to health. However, it should be noted that the relationship is much more complex.

Based on the chart, the institutional, economic, social-cultural and environmental determinants are the main features of globalization. They can, directly or indirectly, affect the health of the population and hence, impact on the human right to health. Under these broader terminologies, there are more specific features such as global governance, global markets, global environment, global communication and cross-cultural interaction, which influence the distal (for example health policy or health-related policy, economic development and trade regulations, knowledge and social interactions, as well as the ecosystem) and proximal (for instance health services, every-day transactions, physical environment, food and water, and social environment and lifestyle) determinants of health. Distal determinants (which are indirect in nature) have consequences on the proximal (direct nature) factors which in turn affect the right to health of the people. Due to the very nature of globalization, all the features and factors described in the chart are also interconnected and interrelated and one determinant may have non-straightforward impact on the other, which eventually changes the outcome as to how the right to health can be realized in today’s world. All the main features of globalization will be considered. However, special focus is given to free trade, debts and the structural adjustments aspects, because it is arguable that they best illustrate the complexities of the system and how interconnected (in economic, social and cultural terms) they are with
regards to human health and also due to the reason that the main concern of this Chapter concentrates on corporate globalization.

3.3 Institutional Determinant

Under global governance, transnational actors take centre stage to solve issues which go beyond the state and the region. The COMECE Report succinctly summarizes global governance as such,

“Global governance does not mean global government in the form of a centralised body that holds exclusive world power and controls global economic flows and information. Rather, it would provide the capacity for effective and legitimate political decision-making at the global level through international institutions and structures of co-operation, co-ordination and perhaps even shared sovereignty.”366

Undeniably, international institutions and organizations (which constitute the main part of global governance structures) are increasingly influencing health and health-related policies. They also play an important role in driving the realization of the right to health forward (or vice versa). Policies affecting health are shaped by institutions such as the United Nations which include agencies such as UNICEF and UNAIDS, the WHO as well as the World Bank. Powerful countries such the European Union and the United States are also major players, not forgetting the role NGOs play in advancing the cause for the promotion of the right to health.

The proliferation of international and regional documents addressing the international human right to health, as discussed in Chapter One, serve as guidance and incentive for governments to implement such human right. As described in earlier Chapters, international declarations and treaties came about as a result of the initiatives of the international organizations, and States Parties that ratify the documents have the responsibilities of putting into operation the relevant human rights, thus influencing how governments draw up health or health-related policies, which have an impact on the health of the people.

The WTO, established in 1995, is a major force under economic globalization through its multilateral trade system, and its role in shaping health policies (directly or indirectly) should not be underestimated. Essentially, the basic principles of the WTO trading system are, firstly, national treatment – treating foreigners and locals equally, secondly, freer trade – the lifting of trade barriers through negotiations, and thirdly, encourage competition - discouraging “unfair” practices such as export subsidies and dumping products at below cost to gain market share.\(^\text{367}\) There are several aspects of the WTO’s trade agreements and practices which have consequences on the social, economic and cultural pathways connecting globalization and health, and a few examples are shown below.

The Sanitary and Phytosanitary Measures Agreement concerns the application of food safety and animal and plant health regulations, even if this may sometimes result in trade restrictions, so long as the regulations are based on scientific risk assessment. This means that countries may enforce measures necessary to ensure that food is safe for consumers,\(^\text{367}\) World Trade Organization, ‘Understanding the WTO: Basic Principles of the Trading System’, http://www.wto.org/english/thewto_e/whatis_e/tif_e/fact2_e.htm, accessed 6 November 2007.
and to prevent the spread of pests or diseases among animals and plants, which is a display of how global governance may affect the implementation of domestic health (or health-related policies). However, critics of the agreement point out how it can be used in ways that discriminate against developing countries, such as when the European Union imposed a tougher standard than any other nation on aflatoxin contamination of dried fruits and nuts, resulting in an anticipated loss of US$ 670 million a year in agricultural export revenues for African countries. Labonte also argued that the risk assessment condition invariably favours producers and exporting countries over citizens and importing countries, as there is no cost to them even if eventually their products are found to be harmful. It is arguable that this involves a balancing act between a country’s right to the highest level of health protection measures and trade-related concerns.

The Technical Barriers to Trade Agreement tries to ensure that regulations, standards, testing and certification procedures do not create unnecessary obstacles to trade – meaning that domestic regulations should be to restrict trade as little as possible. Nonetheless, Article XX(b) of General Agreement on Tariffs and Trade 1994 permits exception to WTO rules, including the aforementioned Agreement, when it is “necessary to protect human, animal or plant life or health.” This seems to recognize a permitted level of health protection, such as France’s success in keeping a ban on the use of

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asbestos products (despite Canada’s appeal against the ban) in order to protect the health of its population and its workers, due to the overwhelming evidence of cancer-causing properties of asbestos. However, the burden of proof that the exception is not invoked as a form of protectionism in disguise is on the country wishing to derogate from trade rules under the exception, and this may limit the affectability of the exemption to protect health.

The TRIPS Agreement, which introduced intellectual property rules into the multilateral trading system for the first time, also seems to have safeguards to ensure access to drugs is not impeded in poorer countries. However, ambiguity exists in applying the exceptions to patent protection. Thus, it appears that the current trade agreements under the WTO are “frustratingly vague in their approach to the task of balancing protection for health against other trade-related concerns” and this may affect the development of policies and programmes connected to promoting health as a human right.

Of course, national policies still play a role in determining the health of the people and accordingly shaping how the right to health is realized. Nevertheless globalization may limit the ability of national and sub-national governments to make policy choices that would lead to improvements in health, such as redistributing wealth, either directly or through public provision and financing of goods and services, and regulating the operation of markets and for-profit enterprises. The next section looks at how intricate

374 This topic is covered extensively in Chapter Four.
and complex the pathways to the right to health are, using the debt and structural adjustment experiences as a setting.

3.3.1 Debt and Structural Adjustment

Following an ideology known as neoliberalism, spearheaded by institutions such as the World Bank and the International Monetary Fund (IMF) as well as other institutions known as the ‘Washington Consensus’ (partly because of the fact that they are based in Washington D.C.), structural adjustment is now a term associated with economic policies enforced in developing countries. This specifically refers to the conditions developing countries must follow in order to obtain new loans from the IMF or the World Bank or to get favourable interest rates on existing loans.

Accordingly, national governments in both poor and middle-income countries, being in a situation where they are in desperate need for funds, put on what Thomas Friedman calls the ‘Golden Straitjacket’.377 This comes in the form of structural adjustment programmes and as Friedman puts it in a nutshell, the resulting golden rules must be adopted:

“… [by] making the private sector the primary engine of its economy growth, maintaining a low rate of inflation and price stability, shrinking the size of its state bureaucracy, maintaining as close to a balanced budget as possible, if not a surplus; eliminating and lowering tariffs on imported goods, removing restrictions on foreign investments, getting rid of quotas and domestic monopolies, increasing exports, privatizing state-owned industries and utilities, deregulating capital markets, making its currency convertible, opening its industries, stock and bond markets to direct foreign ownership and investment, deregulating its

economy to promote as much domestic competition as possible, eliminating government corruption, subsidies and kickbacks as much as possible, [and] opening its banking and telecommunications systems to private ownership and competition…” 378

Regrettably, the human cost of this ‘one size fits all’ policy includes (1) increasing unemployment, as the economic growth fails to ‘trickle down’ or keep pace with the loss of public sector jobs, and local, small producers (many of them women) became displaced by export production and foreign goods;379 (2) the rapid growth of the informal sector which consists of precariously self-employed street vendors, workers in small workshops, temporary day labourers, domestic servants and the like;380 (3) the reduction of social benefits and services on which working-class and poorer sectors of the population depend on; and (4) the inability of the state to provide ‘safety nets’ any longer, due to the shrinkage of public revenues from lowering of tariffs on imports and taxes on capital.381

More specifically, Health Sector Reform has often been referred to mean the set of policies imposed by the World Bank and the IMF under the wrappers of its structural adjustment programmes.382 Lee is of the view that Health Sector Reform is a more on-

378 Ibid.
going process than the term suggests, whereby governments in all countries periodically reflect on, and adjust, aspects of national health systems to meet changing needs. Its advocates argue that governments had grown too large and unwieldy, needing instead to pull back from the direct provision of many public services including health care. A minimalist role for the government is envisioned that involves guiding and facilitating economic development, rather than actually implementing policy decisions. The latter would be left to private sector actors within a competitive market.

As Pasha, who writes about globalization and inequality in South Asia, describes it, neoliberalism may mean a bigger change in the role of the State. From once aspiring to be the ‘gatekeeper’ of the “national” interests and the main actor in political economy, the State has now been thrust into the role of the ‘great facilitator of international capital movements, technology and investment’. This is because the State must now accommodate the market in allocating resources and to help adapt the national economy to globalization.

The transition in the role of the State, especially regarding the social health aspects, means reducing or limiting the social benefits and services in the health department. This includes imposing tight and reduced fiscal limits on public health care spending; promoting user fees and community-based financing; and transferring or out-sourcing functions to the private sector. The WTO, together with a number of bilateral and regional trade agreements, have influenced the design of health care systems by reducing

386 *Ibid*. 
the cross border ‘trade’ in health care and facilitating the entry of corporate health businesses to operate more freely within health care systems of countries.

Kay and Gwynne wrote about the attempts of democratic governments to explain and justify these scenarios in two ways. Firstly, it is argued that the negative social impacts reflect a temporary adjustment to new conditions and will be soon turned around.\(^{387}\) Unemployment and poverty will show a short-term increase in statistics as the economy adjusts to new external realities and as the country forges a better competitive economy. The second reasoning concerns the ‘lack of alternatives’ argument.\(^{388}\) For instance, Latin American treasury ministers point out how the political economy of neoliberalism has becomes the basis for policy in other areas of the world and therefore it is important to ‘modernize’ their economies to give them a more competitive edge in world markets and so that they can better take advantage of global forces.\(^{389}\) This means countries, especially in the developing world, are increasingly feeling the pressure to conform to the modern market rules (commonly dictated by developed countries in the Western World) for fear of losing out to others, even though the way capitalism operates may not provide the best level playing field for them.


\(^{388}\) Ibid.

\(^{389}\) Ibid, 60
3.3.1(a) Privatization of Health Care Systems and Introduction of User Fees

“Along with this erosion of boundaries across societies, regions and cultures comes an evaporation within societies of the distinction between public and private spaces, between the ‘social’ and ‘the individual’ or ‘personal’, that was modernism’s principal way of understanding itself. And with the demise of that distinction comes, not only the vulnerability of individuals and communities to constant (commercial, sexual, ideological, military) invasion and scrutiny, but also … the disappearance of … ‘the idea of publicness’, that is, a sense of public obligations and social rights concerning the health and well-being of people and their environments.”

The erosion of the notion of providing free and public health services is arguably an increasingly pronounced idea and aim when it comes to corporate globalization. The argument that the market will work matters out and that governments should reduce their role in social and public provisions of services means the increasing development of private sectors’ role in traditionally government responsibilities. This can be seen in the health care sectors of the developing world.

International policies for the private sector have been predicated on the assumptions that firstly, it is necessary to achieve higher allocative and productive efficiency; secondly, to reinforce the role of the private sector in the economy; thirdly, to improve the public

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sector's financial health (lower deficits and debts); and finally, to free resources for allocation in other important areas of government activity.\textsuperscript{391}

Private providers may provide an alternative to better health services in the absence of effective or efficient public health facilities. The idea that competition in the private sphere (even with regards to health services) creates initiatives on the part of all health providers to improve their respective services means that the end benefits will be enjoyed by the consumers (patients). On the other hand, private health care is at times associated with profits and preferential treatment of higher income groups. It is arguable a quest to maximize profits may result in a neglect of the ultimate aim of health care providers – to maximize access to health. This is because private providers need to bear in mind the interests of shareholders, who usually expect 10\% to 15\% returns on their investments and taxes may account for 5\% to 6\% of total expenses.\textsuperscript{392} With this in mind, private providers must generate enough profits to pay the shareholders as well as the relevant taxes, while at the same time balancing the need to provide the same quality care as non-profit oriented health providers.\textsuperscript{393}

The availability of various health providers means that users have a choice as to which provider serves their interests best. In theory, choices create awareness of the services or products and accordingly improve the provision of health care as more and more people recognize, demand and obtain higher quality standards of health care. In most cases, users can identify what constitutes good quality health care, however, expectations that increased user knowledge and confidence are enough to improve the quality of services


\textsuperscript{393} Ibid.
are unrealistic, especially in relation to the appropriateness, quality, and availability of drugs and diagnostic tests, and even more so for more complex clinical services.\textsuperscript{394} This means that most people lack the necessary knowledge (especially about technical qualities of health services) to make informed choices about the relative value of different providers, which can further inhibit the right to health. This is made even more difficult when one considers the factor of user fees in health care.

Indeed, another aspect of health sector reform is the introduction of user fees which are monetary charges levied on primary health care in the developing countries. Supporters of this measure recommended the use in two situations: firstly, as a way to mobilize more funds for health care than existing sources provide (when health spending in total is low or falling); and secondly (which is paradoxical to the first scenario), as a method of imposing efficiency by moderating demand and containing costs (when health expenditure is high or increasing rapidly).\textsuperscript{395} Accordingly, McPake argued that the introduction of user fees for public health services will produce improvements in efficiency and equity.\textsuperscript{396} Allocative efficiency (the allocation of resources to those goods and services for which society has the highest values) would show progress because inconsequential use of health services would be discouraged - thus, the resources would be focused on more valuable interventions.\textsuperscript{397}


\textsuperscript{397} \textit{Ibid.}
However, the continuing application of user fees is a controversial issue due to its potential in affecting the right to health of the people. Critics argue that user fees can dissuade people from accessing health care services and this clearly affects the right to health of the people due to their inability of achieving the ‘highest attainable standard of physical health’. For instance, a WHO finding on the implementation of user fees in immunization in developing countries concluded that such charges discourage people from seeking vaccination for themselves and their children and that user fees should not be used for essential immunization services.\(^{398}\) For elderly people in China, medical cost (in the form of user fees) is the main reason for 40% of those not visiting a doctor and 75% of those not gaining admission to hospitals.\(^{399}\) Thus, user fees create financial barriers to accessibility of health care, a problem much more profound for people in the low-income bracket.

User fees also create additional financial strains on the expenditure of the poor, making the poor poorer and further aggravating levels of poverty. By burdening sickness with costs, it is arguable that even a small level of fee can contribute to the impoverishment of vulnerable households.\(^{400}\) They may need to sell key assets, cut down on other necessary expenditures, or borrow, often at exorbitant interest rates, to pay for health care and cope with the loss of income resulting from illness.\(^{401}\) This strain on the household budget is a


\(^{400}\) Gilson, Lucy and Di McIntyre, ‘Removing User Fees for Primary Care in Africa: The Need for Careful Action’,(2005) *BMJ* 331:762-765, [http://www.bmj.com/cgi/content/full/331/7519/762](http://www.bmj.com/cgi/content/full/331/7519/762), accessed 7 December 2007.

\(^{401}\) *Ibid.*
factor leading to inequality in the health care system and the difficulty of realizing one’s right to health.

Hence, it is possible to conclude that privatization and user fees can have impacts on the accessibility of health care services, at times posing as barriers to essential health care especially in developing countries. The next section further expands on the effectiveness of structural adjustment programmes and how it affects the right to health in a more general context.

3.3.2 The Effectiveness of Structural Adjustments Programmes

This section explores some of the general consequences of structural adjustments schemes and in particular their effects on health outcomes among the poor. It is interesting to note how structural adjustments can be traced back to the historical roots of the debt crisis of the late 1970s to mid-1980s and the historical events that shaped countries and regions. The oil crisis from the early 1970s and resulting worldwide recession put an end to the post-war boom; the latter hastened by stringent financial policies in high income countries including tight credit, higher interest rates and reduced public spending.402 The resulting economic slowdown affected low income countries through a reduced demand for primary commodities and cuts in foreign aid, which together with deteriorating terms of trade, led to a reversal in the flow of capital.403 This meant that low income countries, particularly oil-importing countries, saw more monetary resources going outwards than inwards and became even more encumbered by huge foreign debts. This is relevant in understanding that the crisis was primarily the

403 Ibid.
result of mismanagement and ‘corruption’ in poorer countries. It would also be erroneous to put the blame solely on the shoulders of either the governments of debtor nations or on creditor nations and their commercial banks.

Africa can serve as an illustration. Critical social scientists have acknowledged the destructive effects of internal patterns within African countries. However, they argued that these must not be understood narrowly as the ‘irrational’ policies or individual failings of African leaders. The cumulative consequences of the slave trade, violent colonial conquest, and the brutal extraction of natural resources by imperial powers created an enduring legacy of structural imbalances and entrenched inequalities between Africa and the West, and between rich and poor within Africa. Statistics from earlier sections illustrate the striking disparities between Africa and the Western countries. Perhaps it is possible to argue that the policies pursued by both creditors and debtors are responsible for accentuating the economic and social situations; therefore, both must share the burden of adjustment equally.

How did these programmes work in practice? Bingha and Zwi argue that donor agencies and influential policy setters have a responsibility to ensure that the policies they promote are well-founded and based on careful theoretical and empirical analysis, pilot projects and experimentation, and on vigorous monitoring and evaluation. This is especially so

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405 Ibid.


when aid is conditional on policy implementation. It is possible that Health Ministries of developing countries, being under-resourced in terms of materials and relevant knowledge, are disadvantaged when negotiating key policies with international players. Indeed, it seemed that structural adjustments worked very well to manage one dimension of the crisis: ensuring repayment of debts to lending institutions in wealthy countries. According to the Jubilee Debt Campaign organization,

“The total external debt of the very poorest countries (the ‘low income countries’ which have an annual average income of less than $935 per person) was US $375 billion in 2006. During 2006, these countries paid over $34 billion to the rich world in debt service (payments of interest and principal) – that is $94 million a day.”

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Meanwhile, the total external debt owed by the poorest 144 countries was about US $2.9 trillion in 2006 and $573 billion was paid to continue repayment of these debts over the course of 2006.409

On the other hand, structural adjustments did not reduce debts or eradicate poverty, nor return countries to the path of growth. In 1970, the world’s poorest countries (estimated of 60 countries classified as low income by the World Bank) owed US $25 billion in debts and by 2002 this had grown to US$523 billion.410 Besides, the absolute dollar value of debt reveals nothing about the amount of debt in relation to the size of poor countries’ economies. It has been suggested that cancelling African countries’ debts, thus releasing government budgets from the burden of debt servicing, supports increases in tax revenues

408 Jubilee Debt Campaign, ‘How Big is the Debt of Poor Countries?’, http://www.jubileedebtcampaign.org.uk/2%20How%20big%20is%20the%20debt%20of%20poor%20countries%3F%26f%26w, accessed 3 May 2009.

409 Ibid.

allocated to health services.\textsuperscript{411} There has been increasing call for debt relief in recent years and so far, more than 23 of the world’s poorest countries have received US $88 billion in debt cancellation. Despite this figure, more progress is still needed to solve the debt crisis and debts will continue to deplete the resources of impoverished countries which should be spent on healthcare and other public services.\textsuperscript{412}

The debt problem of poor countries can exact a cruel toll in declining life quality, physical and psychological suffering, and squandered human potential, as debt repayment takes precedence over urgently needed social investment in health and education. Some figures to shed some light on the human deprivation associated with crushing debt burdens:

- The poorest nations in Africa had transferred US$167 billion in debt service to their creditors in the first world by the end of 2002.\textsuperscript{413} This was more than the governments spending on health and education of their citizens.

- Ironically, sub-Saharan Africa has 25\% of the world’s disease burden, but only 1.3\% of the trained workforce; altogether it paid more than US$23 billion in debt repayments in 2005.\textsuperscript{414}

- In 2004, Ecuador spent 12\% of its GDP servicing its debts, but only allocated 2.2\% of GDP on healthcare and 1\% on education.\textsuperscript{415}


\textsuperscript{415} \textit{Ibid}.
In Nicaragua, where three out of every four people live below the poverty line; where one quarter of the population suffers nutritional deficiency; and where 35 percent of the population is illiterate, debt repayments exceed the total social budget.416

- In Bolivia, where greater than 80 percent of the highland population lives in poverty; where only 16 percent of that population has access to clean water; and where more than one-third of all women are illiterate, debt repayments for 1997 accounted for three times the spending allocated for rural poverty reduction.417

Through their obligations to the IMF and the World Bank, some aspects of the developing countries’ national life (such as health and education) are rendered even worse and force poor countries to violate some of the most basic standards of human rights. For poor countries, it is obvious that the debt crisis and the ensuing structural adjustment programmes are crucial in affecting the health of the people and accordingly impeding the realization of the right to health. The next section further discusses the determinant of health from an economic perspective, which in many ways is interlinked with the institutional determinant.

3.4 Economic Determinant

In a general sense, globalization means the emergence of a global market, which is meant to facilitate economic growth that brings benefits to health. However, with economic development also comes trade regulations (usually pro-free market) such as those imposed by the World Bank or the IMF, which affects every-day transactions and this has


417 Ibid.
the potential to affect the health of the people through various means – this is explored in
detail in the following section, whereas the other aspect of this determinant (intellectual
property rights and access to medicines) is discussed in Chapter Four.

3.4.1 Free Trade, But Is It Really ‘Free’?

‘As the world sails into the new millennium, there is no doubt that
transnational corporations are at the helm, piloting and propelling global
geopolitics and the process of globalization.’

Free trade refers to the unhindered movement of goods and services on an international
scale. As quoted by Rupert, the development of a global trading regime is summarized as
such:

“By the 1970s a largely free trade order had been established among all the
OECD countries and since the 1980s this has been extended to developing
countries and countries formerly closed to trade under communism, with the
result that a global trading system now exists. Historically, protection levels
are lower than in previous eras while trade liberalization is likely to
continue. Trade levels are higher, both absolutely and in relation to output,
than ever before.”

Though theoretically at liberty to roam the world, most trade today remains concentrated
among the OECD countries; the European Union (EU), the United States, Canada and
Japan combined have nearly the same share of world merchandise exports and imports
(46.3 percent of exports and 46.6 percent of imports) as does the rest of the world

London: Routledge, 45.
A fact to keep in mind then, is that most trade in the world is concentrated in rich countries.

Another fact to consider is that the new global trade does not look like the classic textbook models of trade. One important process of globalization is the emergence of multinational firms and the transnational organization of production. One indicator of this development is the dramatic growth in the stocks and flows of direct foreign investment (DFI) compared to world income, and even sometimes trade. This shows the increases in the magnitude of transnational enterprise. Reflecting this trend, the UNDP 2000 reports that “transnational corporations and their foreign affiliates produced 25 percent of global output in 1998, and the top 100 … had sales totaling $4 trillion.” These corporations and their 250,000 foreign affiliates account for most of the industrial and technological capacity worldwide and in international financial transactions. They also show dominance in producing many of the world’s agricultural crops, while processing and distributing much of its food.

Multinational firms, transnational production, and intra-firm trade have emerged as important forms of global economic linkage. A significant amount of ‘trade’ (estimates range from 30 to 40 percent) actually consists of transactions within the same transnational corporations. This means that Company A, located in Country X, sells its

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421 Ibid.
425 Ibid.
products to a subsidiary in Country B. As trade barriers become lenient, companies (in order to reduce costs of production) move their labour-intensive parts of the production processes to countries with lower-wage and less-stringent labour protection. Indeed, this is an advantage that free market proponents argue is good for the world – larger and efficient production of goods and services lower the cost of products, leading to cheaper goods which increases the standard of living of people (because people are able to afford more).

However, what this argument fails to take into consideration is the effects it may have on the lives of people in the developing world and the realization of the right to health of people caught in the web of such economic globalization. Small, low-income countries in Africa and the Caribbean find that their products – especially textiles, clothing and agricultural goods – are still shut out of the lucrative markets by Western governments trying to protect their own farmers and industry (‘free trade’ for us and not for you). Indeed, Norberg-Hodge characterizes globalization as a series of so-called ‘free’ trade treaties whereby,

“Governments deregulate international capital flows and trade. The process depends on a continuous expansion of global transport and communications infrastructures and favours large multinational corporations and speculative investors. At the same time that international trade is deregulated, a tightening of regulations at the local and the

national level is destroying millions of small producers and local and national businesses worldwide.**427

The so-called ‘benefits’ of the global market integration and liberalization accrue disproportionately to the most powerful countries and people, and these inequities receive tacit approval from the multilateral trade regime of the World Trade Organization (WTO).**428 In order to promote “predictable and growing access” to the world’s markets, the GATT-WTO regime has sought to institutionalize on a multilateral basis international norms of non-discrimination (between domestically produced and imported goods) through such legal means as “most favored nation” and “national treatment provisions”.**429 The WTO defends its mission by arguing for why a world of multilateral openness and market-led growth is a better alternative than protectionism and stagnation:

“The alternative [to openness] is [import protection] and perpetual government subsidies [that] lead to bloated, inefficient companies supplying consumers with outdated, unattractive products. Ultimately, factories close and jobs are lost despite the protection and subsidies. If other governments around the world pursue the same policies, markets contract and world economic activity is reduced. One of the objectives of the WTO is to prevent such a self-defeating and destructive drift into protectionism.” **430

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430 Ibid.
Critics of protectionism support the above contention by pointing out the relative shortcomings when countries fail to follow the trend of trade openness. For instance, Sub-Saharan African share of world exports has been declining despite trade protectionism for the reason that domestic producers (dependant on their captive domestic market to keep them afloat) see no need to make their products better and cheaper.\footnote{Tupy, Marian, ‘Free Trade Benefits All’, (2006), \url{http://www.cato.org/pub_display.php?pub_id=5354}, accessed 5 November 2007.} Panagariya linked trade openness with poverty alleviation, stating that because poor countries tend to export labour-intensive products, removal of trade restrictions will encourage the products’ export and increase the demand for and consequently incomes of labour.\footnote{Panagariya, Arvind, ‘Miracles and Debacles: Do Free-trade Skeptics have a Case?’, (2003) \url{http://129.3.20.41/eps/it/papers/0308/0308013.pdf}, accessed 5 September 2008.} Another argument was that liberalization removed discrimination against agriculture (which employed the bulk of the poor) and this was more likely to benefit the poor than on the contrary.\footnote{\textit{Ibid.}}

This is in line with the International Monetary Fund’s (IMF) ideology which states that new and more productive jobs will be created as the old, inefficient jobs that have been created under protectionist policies are eliminated.\footnote{Stiglitz, Joseph, \textit{Globalization and Its Discontents}, (2003) London: Penguin, 59.} However, this was disputed by Stiglitz who argued that it takes capital and entrepreneurship to create new firms and jobs, but the reality is that there is often a shortage of the latter (due to lack of education) and the former (due to lack of bank financing) in the developing countries.\footnote{\textit{Ibid.}}

Ironically, it is arguable that the notion of free trade is one-sided, favouring developed countries more than developing countries. As quoted by Pogge,
“Rich countries cut their tariffs by less in the Uruguay Round than poor ones did. Since then, they have found new ways to close their markets, notably by imposing anti-dumping duties on imports they deem ‘unfairly cheap’. Rich countries are particularly protectionist in many of the sectors where developing countries are best to compete, such as agriculture, textiles and clothing. As a result … rich countries average tariffs on manufacturing imports from poor countries are four times higher than those on imports from other rich countries. This imposes a big burden on poor countries which eventually resulted in the decrease of development fund or budget”\[436\]

An example as to how trade is not ‘free’ can be seen with the TRIPS agreement and how it sought to protect intellectual property rights, most of which are held by entities in the developed world.\[437\]

The question remains as to whether the global phenomenon of free trade is detrimental to the human right to health. There is no doubt that globalization has its benefits, but it is also possible to see the direct and indirect effects of trade liberalization on the human health, especially when one takes into account the fact that health is all encompassing, and involves more than just adequate health care. Certain economic policies may have negative effects on the social, cultural and economic spheres of the people and this can affect their right to health because all these factors are inter-connected (be it linear or non-linear) and one factor can have some kind of impact on the other.


\[437\] See Chapter Four of thesis.
With the encroachment of WTO policies into the domestic spheres, it is common to see scenarios of people losing their jobs as a result of local industries closing down (due to foreign companies competing away the local markets). Poor people, usually in developing countries, are in a weaker position to protect themselves from the series of vicious spirals – lack of job means a lack of income, which leads to inability to feed oneself or the family, which leads to ill health, which again affects their earning ability, leading to even poorer health. Ill health can also have social repercussions as well. Inability to provide an income means the incapability of some parents to send their children to school, or children have to stop school to seek employment in factories to earn income to provide for the family. Lack of education also means that future generations are condemned to the nasty cycles of poverty, which also implies the difficulty of realizing one’s right to health. This is how free trade, poverty and human rights are connected.

Just as the globalizing world of today is marred by striking inequalities and unevenness in the sharing of opportunities and risk, so is this reflected in the health sector. More than 90% of HIV infections are in the developing world and that the poorest 20% of the world’s population have a fourteen fold higher risk of death in childhood than the richest 20%. According to the Global Forum for Health Research 2000 in ‘The 10/90 Report on Health Research’, less than 10% of global spending (1992 estimate of US$ 56 billion) on health research is devoted to 90% of the world’s health problems. The World Health

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439 Ibid, 17.
440 Ibid.
Report 1999 states that nearly 30% of deaths in the developing world are from infectious diseases, yet only 1.5% of foreign aid is directed towards their eradication.\textsuperscript{441}

As noted above, the link between globalization and sicknesses of individuals is often non-linear. Still, it is possible to link the prevalence of HIV infections among the population to the emergence of the free market in Ghana, which is actively encouraged by international agencies dominated by high-income countries. Ghana began to liberalize trade in 1986,\textsuperscript{442} as part of a structural adjustment programme attached to loans from the IMF; and with it came the opening of its border to imports including new, cheaper and better marketed goods. Its domestic manufacturers, inept in both technology and management by richer nation standard, produced more expensive and lower quality goods. Overall, they could not compete especially when the importers had the advantage of low production costs and no import duties. The result: employment in manufacturing fell from 78,700 in 1987 to 28,000 in 1993.\textsuperscript{443} Stiglitz is accurate when he comments on how the critics of globalization are right in accusing Western countries of hypocrisy.\textsuperscript{444}

By keeping up their own barriers while at the same time pushing poor countries to eliminate trade barriers, they managed to prevent developing countries from exporting their agricultural goods and so depriving them of desperately needed export income.\textsuperscript{445}

For conventional economists, this is a textbook example of how and why trade liberalization works: consumers get better and cheaper goods; and inefficient producers are driven out of business. The theory is such that “those industries with a comparative


\textsuperscript{443} \textit{Ibid.}


\textsuperscript{445} \textit{Ibid.}
advantage will benefit from the export opportunities of openness, while other industries may face stiffer competition from imports and could be substantially harmed. Yet, economists maintain that freer trade will yield a net gain for the overall economy, as the gains made available by exploiting comparative advantage will outweigh the losses to less efficient domestic industries, and consumers will enjoy enhanced consumption possibilities.

However, the average population of Ghanaians paid a heavy price. Structural adjustment programme and the privatization of state enterprises eliminated a further source of revenue that might have been used to support social programmes such as education and healthcare. This is the typical scenario happening not just in Ghana, but in other poor countries as well, which prompt governments to start imposing user fees on public services to reflect declining public proceeds. Not surprisingly, costs became one of the main reason people failed to seek healthcare or did not follow up medical treatment.

Corporate representatives often suggest to their critics that it is not their wish or intention to ‘trample third world sovereignty’ and ‘imperiously’ enforce western values and western laws on developing countries. However, according to Luttwak, its proponents are ‘painfully aware’ of the greatest weakness of globalization – that while globalization or ‘turbo-capitalism’ as he terms it, imposes its disruptions on all in perfect equality, its benefits are disproportionately endowed upon a select few. Indeed, the dynamics of the world economy are such that most third world countries are in competition with one

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another to attract foreign investment, which resulted in their governments’ reluctance to 
tighten or enforce laws and regulations so as not to create an environment that turns away 
investment from corporations. Unfortunately, many global corporations are fully aware of 
these situations and regularly take advantage of them to keep costs down, thereby 
effectively imposing their own interests on the legislative and regulatory processes of 
poorer countries.

The web of connection between globalization and the human right to health has many 
strands and the environmental aspect will be explored in the next section.

3.5 Environmental Determinant

The issue of global warming and how the human ecological footprint (or that of 
countries) may bring about drastic environmental changes, which affect the world 
ecosystem and accordingly influence the nature of the physical environment as well as 
the food and water supply (which have a bearing on the human health), is emerging as a 
significant threat to health.

By selecting climate change as the theme for World Health Day 2008,451 the WHO is 
drawing attention to the consequences climate change may have on human health. 
Humans are affected by disruptions in the ecosystems, water, air and food quality as well 
as extreme weather events, and such exposure may bring obvious health hazards such as 
ill-health, deaths and suffering.

According to the Inter-governmental Panel on Climate Change’s (IPCC) Third 
Assessment Report,

451 See Statement of WHO Director-General- Dr Margaret Chan, ‘The Impact of Climate Change 
on Human Health’, (2008) 
2008.
“[Firstly] an increase in the frequency or intensity of heat waves will increase the risk of mortality and morbidity, principally in older age groups and among the urban poor…[secondly] any regional increases in climate extremes (for example storms, floods, cyclones, droughts) associated with climate change would cause deaths and injuries, population displacement, and adverse effects on food production, freshwater availability and quality, and would increase the risks of infectious disease, particularly in low-income countries.”\textsuperscript{452}

Extreme weather patterns mean the chances of storms and other natural disasters causing deaths and injuries will increase and natural catastrophes also bring about outbreaks of diseases such as cholera, diarrhea and other infectious viruses. In the past 30 years, warmer temperatures have also created more favourable conditions for mosquito populations in the East African highlands and consequently for the transmission of malaria.\textsuperscript{453}

A lack of access to clean water can compromise hygiene and health. According to the WHO, this increases the risk of diarrhoea, which kills approximately 1.8 million people every year, as well as trachoma (an eye infection that can lead to blindness) and other illnesses.\textsuperscript{454}

The agricultural sector is vulnerable to weather variability, and this may jeopardize food security especially in the world’s poorest regions. It is estimated that by 2020, yields


from rain-fed agriculture could be reduced by up to 50% in some countries, which means that agricultural production (including access to food) in many African countries is projected to be severely compromised. This would further adversely affect food security and aggravate malnutrition which causes millions of deaths each year.

From the perspective of the environment, the underlying determinants of health are not often straightforward, though it is increasingly being recognized that not endangering the ecosystem much further and improving access to clean air, water, sanitation are central to the maintenance of human health and to reduce infant and child mortality. However, given that the link between the environmental determinant and the right to health is more indirect in nature, it is beyond the scope of this thesis to elaborate in detail the relationship between global warming and its effect on health.

3.6 Social-Cultural Determinant

Under the synergies of global communication and cross-cultural interactions, the diffusion of knowledge and technology are perceived to be one of the most important vehicles in promoting human rights - the right to health included - in today’s world. The advances of new technologies had enabled new vaccines to be researched, new drugs to be developed and current health facilities and knowledge to be improved on. It is arguable that by integrating the use of modern innovations into tackling health issues in the developing countries, positive progress in health can be yielded. For example, hand-held computers and mobile devices used in Botswana show early indications of improving data quality and the efficiency of operation in HIV voluntary counseling and

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testing programmes.\textsuperscript{456} Such technologies had also helped the malaria spraying campaign in terms of data collection and mapping in Mozambique. What is essential is that globalization allows the sharing of crucial knowledge in promoting better and efficient ways of health care, and this is important in the advocacy of how important the right to health is.\textsuperscript{457} Thus, globalization creates a window of opportunity for which information can travel easily and globally and thus, enable the sharing of new advancements in the health sector between countries and nations, accordingly improving the efforts to strengthen the realization of the right to health.

Globalization facilitates transfer of knowledge and the dissemination of information on a worldwide scale. People nowadays have the advantages of accessing information and news through different means, anytime, anywhere. Increasing cross-cultural interaction means that global actors in global health can co-operate together to accelerate the process of advancing the right to health; and global communication serves as a vehicle promoting advocacy of human rights and the issues relating to its implementation.

It is also worth noting that increasing cross-cultural relations, through widespread flow of people, ideas and information, influence the lifestyles of people throughout the world. It is widely acknowledge that several modern behavioural factors such as unhealthy diet, physical inactivity, alcohol and illicit drug misuse have significant impact on the human health. The current lifestyle choices available in the world, be they healthy or detrimental, are also affected by global trade, economic development as well as the environment.

The right to health cannot be exercised fully without the holder of such right knowing that it exists. Social-cultural aspects of globalization contribute to the realization of the


\textsuperscript{457} Ibid.
right to health through information and education of right holders of the existence of their right, or an awakening of a sense of civic engagement with the aim that such right shall exist.

4. Conclusion

This chapter considered the human right to health and the issue of human health from a broader perspective. The ongoing process of corporate or economic globalization and the worrying social, cultural and economic repercussions of poverty continue to shape people’s way of living everyday and determine (both directly and indirectly) people’s health status (and hence their the extent to which they can realize their right to health) across the globe. However, as the chapter has illustrated, the impacts of globalization and poverty on health seem to paint a rather bleak picture.

Globalization brings profound changes and complexities into the social, political, economic and cultural operations of society, and as chart 1 illustrated, the causal pathways between the worldwide phenomenon of globalization and the right to health are varied and multifaceted, and that events or happenings in one part of the world can lead to significant changes in people’s lives somewhere across the globe. This chapter provided some necessary insight into how different processes simultaneously occur in the many elements of globalization, and accordingly influence the institutional, economic, social-cultural and environmental determinants of the right to health.

However, the linkages between globalization and the right to health do not end here. The next chapter continues to examine how intricacies in the world market affect the implementation of human rights, especially focusing on the vital issue of access to
medicines and the developments made in this area with regards to the human right to health.
Chapter Four: Highlighting Access to Medicines as an Issue under Health and Human Rights

Introduction

The previous chapter explored how globalization is an important factor to consider when examining how effective the realization of the human right to health is in reality. Because of the way how everything that happens is interconnected and interrelated on a worldwide scale, it would be ignorant to overlook the influences globalization do have on human rights in general, especially an economic, social and cultural human right such as the right to health. This chapter continues the analysis of the relationship between global social factors and the human right to health by focusing specifically on access to medicines, which is an integral feature in the institutional and economic determinants of health.

Access to essential medicines is a vital part of the human right to health and has appeared as a key public health issue, particularly with the influence of patents on the prices of medicines and the emergence of private pharmaceutical companies as main providers of drugs.

The chapter begins by explaining the gist of what constitutes essential medicines and their importance in global health. It then explores the Trade Related Intellectual Property Rights Agreement (TRIPS) and the role it plays in influencing access to medicines. TRIPS established minimum standards of intellectual property protection to be observed in all WTO members. As these standardized rules mirror those in force in industrialized countries, this means that in reality, developing countries have to bear the more difficult burden of introducing substantial intellectual property rights reforms and this may have
profound and detrimental effects beyond the trade and intellectual property areas. Unfortunately, the relationship between intellectual property and human rights appears not to feature prominently in the WTO framework and this chapter seeks to explain this further.

This chapter also looks at why medicine prices and the role of the generic drug industries are important. Generic drugs are copies of proprietary or brand-named drugs, which are similar in dosage, strength, safety, quality, performance and intended use. The main difference between proprietary drugs and generics is that the latter is produced and dispensed without patent protection. For instance, paracetamol is a chemical ingredient found in a few brand-named painkillers such as Panadol or Tylenol, but it is also being sold as a generic drug (without the label).\(^{458}\) Generics are crucial especially in the developing world because their low price means that they are often the only medicines that the poorest can afford.

The stance and influence of the pharmaceutical industry on the access to medicines are discussed before moving on to significant developments in the debate on access to drugs and intellectual property, especially highlighting the case of South Africa and India and their impacts on access to medicines and the human right to health.

1. Essential Medicines

According to the WHO, essential medicines are those that “satisfy the priority health care needs of the population [and they should be] available within the context of functioning health systems at all times in adequate amount, in the appropriate dosage forms, with assured quality, and at a price the individual and the community can afford.”\(^{459}\) Essential drugs play an important role in global health – for instance, they can be life-saving for diseases such as respiratory infections, tuberculosis and malaria which cause millions of deaths each year. Hence, to facilitate the development of national and institutional essential medicine lists to fight growing health concerns worldwide, the WHO came up with a Model Essential Medicines List in 1977, which is revised every two years to keep up to date with current health woes. The number of essential medicines has expanded from 208 in 1977 to more than 340 today and the first WHO Model List of Essential Drugs for Children was published in 2007. This progress is significant, because it stresses the importance of the notion of essential medicines to improve global health which was underlined in the Alma-Ata Declaration 1978.

Medicines are one of the most important components of health care as they account for a considerable part of household health expenditures. Statistically, pharmaceuticals account for 15% to 30% of health spending in transitional economies and 25% to 66% in developing countries.\(^{460}\) However, as seen in Chapter Three, the capitalist machinery of globalization hinders people’s access to the right to health, which includes their ability to buy medicines, rather than facilitating their access to good health. The rest of this Chapter


examines how the contemporary system of intellectual property rights – arguably a by-product of globalization - makes the necessary and essential drugs much more difficult to be accessed by the people (especially in the developing world) and how this in turn affects the human right to health.

2. TRIPS Agreement and Access to Drugs:

“[the definitions of globalization are two-fold - the] increase in the importance of cross-border economics activities – flow of goods, flow of capital bank lending and flow of people in international migration…has been going on at least for the last couple of centuries, although there were various setbacks and reversal of trends in particular periods. [Secondly, globalization] refers to not only the increase in the importance of cross-border activities but also to the spread of a single set of liberal rules that govern international economic activities, and indeed domestic activities as far as they have a bearing on the former.”

The main instrument for the introduction of medical patents in developing countries is the TRIPS Agreement, which generally seeks to provide minimum levels of intellectual property protection in all WTO countries. The TRIPS regime is a treaty that establishes a public international law regime which is intended to reinforce the protection of intellectual property rights through the establishment of minimum standards and to commit States to provide adequate enforcement mechanisms and access to justice to intellectual property rights holders. Its aim was to create a harmonized global system

461 Madeley, John, A People’s World: Alternatives to Economic Globalization, (2003) London: Zed Books Ltd, 18. The first definition is in line with the aims of current world market policies, whereas the latter describes the general essence of TRIPS.

under which inventors are granted exclusive marketing rights for a minimum of 20 years for ‘new and inventive’ products.

The TRIPS Agreement is one of the most significant achievements of the Uruguay Round\textsuperscript{463} of the General Agreement on Tariff and Trade, as it introduced intellectual property rules into the multilateral trading system for the first time. It is an attempt to narrow the gaps in the way these rights are protected around the world, and to bring them under common international rules. It was signed by 124 nations together with other multilateral trade agreements and the Agreement establishing the WTO.

TRIPS is not an automatic universal regulation and it can only be enforced by the laws of individual countries. Theoretically, if Country $X$ has no intellectual property laws in place, then there is nothing preventing the people from copying a product made by Country $Y$, even though there are laws protecting it in Country $Y$. TRIPS comes into the picture by ‘encouraging’ its Member States to adopt intellectual property rights laws (with threats of harsh penalties by the WTO). Consequently, with the implementation of intellectual property rights laws in Country $X$, country $Y$ could then register the patent for its product with them, thus making copying the product illegal. This scenario as it applies to essential medicines will be discussed further in the present chapter.


\textsuperscript{463} The Uruguay Round was launched in September 1986, in Punta del Este, Uruguay, with ministers from the GATT (General Agreement on Tariffs and Trade) members discussing an agenda that covered virtually every outstanding trade policy issue, notably extending talks into trade in services and intellectual property. It was the biggest negotiating mandate on trade ever agreed; the process ended with the signing of the Final Act of the Marrakesh Agreement in April 1994, and it also transformed the GATT into the WTO. See, World Trade Organization, ‘Understanding the WTO: The Uruguay Round’, \url{www.wto.org/english/thewto_e/tif_e/fact_5.htm}, accessed 2 August 2007; Someshwar, Singh, ‘Uruguay Round - A Historical Perspective’, \url{www.twnside.or.sg/title/hist-sn.htm}, accessed 2 August 2007.
In theory, this system promotes innovation by making sure that those with pioneering ideas are rewarded accordingly. Most of the value of new medicines and other high technology lie in the amount of invention, innovation, research, design and testing involved. Because ideas and knowledge are increasingly becoming an important part of trade, creators should be given the rights to prevent others from using their inventions, designs or other creations — and to use that right to negotiate payment in return for others using them. Intellectual property rights are given by governments to creators as an incentive to generate ideas that will benefit society at large. The extent of protection and enforcement of these rights differs widely around the world, and as intellectual property becomes more important in trade, these differences become a source of tension in international economic relations. New internationally-agreed trade rules for intellectual property rights were seen as a way to introduce more order and predictability, and for disputes to be settled more systematically. 

However, TRIPS was never really understood by developing countries as a good bargain as the Agreement basically universalizes standards of protection that are suitable for industrialized countries, or more precisely, for certain industrial sectors in which firms based in such countries dominate. Many developing countries would have come to a shared consensus with developed countries if the main objective of the TRIPS Agreement was to merely serve as an instrument to combat counterfeiting and piracy. However, the TRIPS agreement is concerned mainly with the interests of intellectual property rights holders; being regarded as a component of a policy of ‘technological protectionism’

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aimed at consolidating an international division of labour whereby Northern countries
generate innovations and Southern countries constitute the market for the resulting
products and services. Though the TRIPS Agreement leaves a certain room for
manoeuvre at the national level, it restricts the options available and ignores the profound
differences in economic and technological capabilities between the North and the South.
Many scholars have recognized the fact that despite the limited scope their name implies,
multilateral trade agreements (MTAs) in reality affect much more than just trade between
national economies, but they have indeed far reaching consequences for all aspects of
social organization. MTAs have in fact been described by Koivusalo, as a legal
instrument for advancing the agenda of economic globalization and transforming the
legal realities of affected countries in such a way, that the previous hierarchy of rights is
gradually shifting away from human rights of individuals towards the private property
rights of corporate entities.

The fact that MTAs have implications that amount to a virtual overhaul of the legal
priorities of subject countries is expressly evidenced by the scholarly works of those
authors who acknowledge the existence of this force for change (MTAs legal effect) - not
because they are opposed to it, but because they welcome it. Advocates of this quiet, but
profound ‘legal revolution’ do not deny its existence, as they see it as a force for good,
one that will in the end better ensure non-discrimination than a system based on social

466 Ibid.
467 For further reading on MTAs and health, see Navarro, V, ‘Comment: Whose Globalization?’,
468 Koivusalo, Meri, ‘Assessing the Health Policy Implications of WTO Trade and Investment
Agreement’, in Correa, Carlos and Yusuf Abdulqawi (ed.), Intellectual Property and
welfare.\textsuperscript{469} This logical chain of causality has been described by Dollar as follows: the unconditional enforcement of corporate intellectual property rights by signatory governments of the TRIPS, even against the individual needs of their own citizens, will lead to increased investor confidence, thus improving trade, which leads to economic growth and ultimately to ‘poverty reduction and better health’.\textsuperscript{470} This is very much in line with the basic understanding as to how the modern capitalist market should operate under globalization.\textsuperscript{471} Accordingly, the next question arises: how exactly does TRIPS functions?

2.1 How Does TRIPS Work?

Despite the origins of and main forces behind the TRIPS Agreement, it is still subject to some limitations and exceptions intended to fine-tune the legitimate interests of rights holders and of consumers. Intellectual property rights are essentially ‘private rights’, but TRIPS also recognizes the underlying public policy objectives of national systems for the protection of intellectual property and reminds Member States that the rules put in place should contribute to the transfer and dissemination of technology in a manner conducive to social and economic welfare.

International practice reveals that international law does not govern in a direct manner the way in which its rules should form part of or be incorporated into national legal orders. A rule of customary international law provides that international law leaves the decision on

\textsuperscript{469} Cf., see Cornia GA, ‘Liberalisation, Globalization and Income Distribution’ (1999) WIDER Working papers 157 Helsinki - the challenge to this perspective is evidence that globalization and liberalization of markets is more closely associated with increased social inequality.


\textsuperscript{471} See Chapter Three of thesis.
the method under which the treaty rules are to be incorporated into the domestic law to the authority of each State, essentially to their constitutional systems.\footnote{Moncayo von Hase, ‘The Application and Interpretation of the Agreement on TRIPS’, in Correa, Carlos and Yusuf Abdulqawi (ed.), \textit{Intellectual Property and International Trade: The TRIPS Agreement}, (1998) London: Kluwer Law International Ltd, 97}

In view of that, Article 1 of the Agreement provides that signatory governments “may, but shall not be obliged to, implement in their law more extensive protection than is required by this Agreement…” and that Members “shall be free to determine the appropriate method of implementing the provisions of this Agreement within their own legal system and practice.”\footnote{Agreement on Trade-Related Aspects of Intellectual Property Rights 1994, \url{http://www.wto.org/english/docs_e/legal_e/27-trips.pdf}, accessed 7 December 2007.} This supposedly offers a defence against any further demand for higher levels of protection or for ignoring the transitional terms provided for by the Agreement.\footnote{Corea, Carlos, \textit{IP Rights, the WTO and Developing Countries: The TRIPS Agreement and Policy Options}, (2000) London: Zed Books Ltd, 8.} At the same time, it explicitly allows a country, if it so wishes, to expand the protection to new areas not covered by the Agreement, such as knowledge in possession of local and indigenous communities.\footnote{\textit{Ibid.}}

Based on proposals submitted by the ‘Group of 14’\footnote{For example, Argentina, Brazil, Chile, China, Columbia, Cuba, India, Egypt, Peru, Nigeria, Tanzania, Uruguay, Zimbabwe & Pakistan} developing countries in May 1990, provisions on objectives (Article 7) and principles (Article 8) were included in the TRIPS agreement. These were prompted by the developing countries’ insistence on the connection between the protection of intellectual property rights and the promotion of social and economic welfare.\footnote{Yusuf, Abdulqawi ‘TRIPS background, Principles and General Provisions’, in Correa, Carlos and Yusuf Abdulqawi (ed.), \textit{Intellectual Property and International Trade: The TRIPS Agreement}, (1998) London: Kluwer Law International Ltd, 10.}
Article 7, entitled ‘Objectives’ reminds Member States of the primary public-policy objectives for which governments grant protection and enforcement of intellectual property rights – that it should “contribute to the promotion of technological innovation and to the transfer and dissemination of technology”. It also recognizes that such enforcement should benefit the producers and users of technological knowledge mutually and in a way “conducive to social and economic welfare, and to a balance of rights and obligations.” This last phrase is rather a reference to the concept of ‘intellectual property bargain’ which has traditionally provided a philosophical underpinning for the enactment of national legislation on intellectual property rights.

Article 8, entitled “Principles”, recognizes the rights of Members to adopt measures “necessary to protect public health and nutrition, and to promote the public interest in sectors of vital importance to their socio-economic and technological development” and to prevent the abuse of intellectual property rights, provided that such measures are consistent with the provisions of the TRIPS Agreement. These provisions, taken together with Article 7, preserve and expand exceptions that Article 5A of the Paris Convention has long recognized, and they explicitly entitle developing countries to assimilate concerns about economic development into these exceptions. They acknowledge that

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479 Ibid.
exceptions to intellectual property rights are imperative mechanisms of the regime and that it could also provide developing countries “with legal basis for maintaining some degree of domestic control over IP policies in a post-TRIPS environment”. 483 The full enjoyment of this flexibility is somewhat curbed by the requirement that such measures should be “consistent with the provisions of this Agreement”. 484 This was not put in the original proposal by the developing countries and was apparently added because developed countries considered it indispensable in view of the broad nature of the public interest principle. 485 Measures aimed at the protection of public health and nutrition may be easily defined, but it is much more difficult to delineate the broader concept of ‘public interest in sectors of vital importance to their socio-economic and technological development’. Hence the limitation imposed through the consistency test, which, in case of dispute between parties to the agreement, provides a yardstick, albeit general and somewhat vague against which such measures may be evaluated. 486 Despite this limitation, there is no doubt that Article 8 offers a considerable degree of legislative flexibility to Member States, on the basis of socio-economic and technological development consideration, in an Agreement that otherwise aims at the establishment of uniform standards on intellectual property rights.

The TRIPS Agreement requires signatory countries to make patents available for any invention, whether products or processes, in all fields of technology without

486 Ibid.
discrimination, provided they fulfill the normal tests of novelty, originality and industrial applicability. However, it allows states to restrict the patentability of inventions contrary to “ordre public or morality”; which means that the protection of human, animal or plant life or health or avoidance of serious prejudice to the environment are explicitly included. The use of this exception is subject to the condition that the decision to do so is not merely based on the fact that the exploitation of invention is prohibited by law. In the context of this chapter, this would forbid a blanket restriction on product patents on pharmaceuticals.

Furthermore, States are allowed via Article 30 to limit the exclusive rights conferred by a patent. The major difference between Article 27.2 and Article 30 is that the latter does not provide States with the luxury of rejecting the patentability of a given drug or any other invention, but only to control its use. Nonetheless, three criteria must be met in order to qualify for an exception: firstly, the exception must be “limited”; secondly, the exception must not “unreasonably conflict with normal exploitation of the patent”; and thirdly, the exception must not “unreasonably prejudice the legitimate interests of the patent owner, taking account of the legitimate interests of third parties”. The three conditions are cumulative, each being a separate and independent requirement that must be satisfied. Thus, the syntax of Article 30 is such that even though there is no definition of what “limited exceptions” entail, failure to comply with any one of the three conditions will result in the unsuccessful application of the Article 30 exception.

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488 See Article 27.2 of TRIPS, Ibid.


490 Supra note 488.


On a more positive note, Cullet is of the view that as there is no definition of “limited exceptions”, Article 30 can be used by countries to pursue public health goals.\textsuperscript{493} The objectives clause of Article 7\textsuperscript{494} can impart further meaning into Article 30 when read alongside the last part of this provision, which provides that States must both avoid the unreasonable prejudice of the interests of patent owners and at the same time, taking into consideration the lawful interests of third parties. On this basis, Cullet argues that there is a possibility for States facing a severe HIV/AIDS crisis to use Article 30 to make exceptions to patent rights to meet the “legitimate interest of third parties” – meaning HIV/AIDS patients who need access to existing life-saving medicines.\textsuperscript{495}

2.2 Compulsory Licensing

The exceptions provided for in Articles 27.2 and 30 are supplemented by Article 31, which provides a regulatory framework for compulsory licensing,\textsuperscript{496} which essentially means that a government can allow a third party to produce the patented product without the consent of the rights’ holder. This acts as a potential instrument for developing countries to control the impact of the introduction of patents, though strict stipulations need to be observed before compulsory licensing is permissible. For instance, compulsory licensing is only allowed based on individual merit;\textsuperscript{497} authorization must be secured from the rights’ holder on commercial terms and conditions unless it is a national emergency or other circumstances of extreme urgency or in cases of public non-

\textsuperscript{494} See Article 7 of TRIPS (emphasis on the call for a balance between the promotion of innovation and the transfer and dissemination of innovation, and for a balance of rights and obligations).
\textsuperscript{496} However, the term “compulsory licensing” does not appear in the TRIPS Agreement.
commercial use;\textsuperscript{498} that the scope and time of the license is limited to the purpose for which it is authorized;\textsuperscript{499} and that it shall be non-exclusive.\textsuperscript{500} In addition, the license is only for the supply of the domestic market of the Member authorizing such use\textsuperscript{501}; the rights’ holder is entitled to adequate remuneration;\textsuperscript{502} and that the legality of the decision taken regarding the endorsement of such license\textsuperscript{503} or any such remuneration is subject to judicial review.\textsuperscript{504}

As Article 31 merely permits the licensing of only individual inventions, clauses allowing the compulsory licensing of a whole group of products, such as medicines in general, would be unacceptable.\textsuperscript{505} Still, an important feature of the provision is that there is no constraint on the purpose for which compulsory licensing can be authorized – this provides Member States with the flexibility of using it to meet public health and other health policy goals. Indeed, as Correa puts it, Article 31 ‘compulsory licensing’ should be considered in light of the Preamble and Part 1 of the TRIPS Agreement.\textsuperscript{506} Reading this together with the text of the Declaration on the TRIPS Agreement and Public Health,\textsuperscript{507} Article 31 leaves States with the freedom to determine what constitutes a national emergency. This is especially useful in the case of health emergencies. Furthermore, it is also recognized that public health crises, including those relating to HIV/AIDS,

\textsuperscript{498} See Article 31 (b) of TRIPS.
\textsuperscript{499} See Article 31 (c) of TRIPS.
\textsuperscript{500} See Article 31 (d) of TRIPS.
\textsuperscript{501} See Article 31 (f) of TRIPS.
\textsuperscript{502} See Article 31 (h) of TRIPS.
\textsuperscript{503} See Article 31 (i) of TRIPS.
\textsuperscript{504} See Article 31 (j) of TRIPS.
\textsuperscript{507} Declaration on the TRIPS Agreement and Public Health, as adopted by the Fourth Session of the WTO Ministerial Conference at Doha on 14 November 2001, WT/Min(01)/Dec/W/2.
tuberculosis, malaria and other epidemics, can represent a national emergency or other circumstances of extreme urgency.\textsuperscript{508} For instance, in August 2005, Tuberculosis was declared an emergency by the WHO in Africa.\textsuperscript{509}

However, according to an Oxfam Report,\textsuperscript{510} one of the main limitations of a compulsory license, in practice, is that a reasonably sophisticated pharmaceutical industry needs to be in place in a country in order to produce the medicine concerned, and must be able to achieve economies of scale to lower the price down to affordable levels. These two factors are what the majority of developing countries fail to achieve. A possible solution would be to import from a generic manufacturer in a larger country (such as India) but this is unlikely to be economically viable unless a compulsory license has also been issued in the exporting country. Even if this is fulfilled, Article 31(f) of TRIPS (which allows compulsory licensing only if it is ‘predominantly’ for domestic needs) can serve as a legal basis for accusing an exporting country of violating the rules of the regime.

Article 31(f) states that compulsory licensing is mainly to supply the domestic markets, which means any intention to export the patented products is prohibited. Under Article 28, patent owners have the right to prevent third parties from “making, using, offering for sale, selling or importing” a product without the authorization of the rights’ holder. However, certain flexibility exists in the form of ‘parallel imports’; with the legal principle being “exhaustion”. Parallel imports are not of the same equation as imports of

\textsuperscript{508} See Section 5(c) of the DOHA Health Declaration 2001, \textit{ibid}.
counterfeit products or unlawful copies. These are products marketed by the patent rights’ holder or with the patent owner’s permission in one country and imported into another country without the approval of the patent owner. Such practices occur because companies usually set different price points for their goods in different countries. To illustrate, drug company X has a drug patented in country A and country B, which it sells at a much lower price in country B. Then, company Y comes into country B, buys the drug and imports it into country A at a lower price than company X’s price - that would be parallel importing. The exhaustion of rights means that once company X has sold a batch of its drugs in country B, its patents rights are exhausted and it no longer has the right to control what happens to that particular batch of drugs.

This is relevant in the context of this chapter because Article 6 states that none of its provisions, except those dealing with non-discrimination, can be used to address the issue of exhaustion of intellectual property rights in a WTO dispute. This implies that countries which do not have the capacity to manufacture certain drugs or which have relatively exorbitant drug prices can make use of this provision to search for cheaper alternatives elsewhere. Besides, the DOHA Health Declaration 2001 further provides that Member States have the freedom to deal with the exhaustion of rights by establishing their own systems that best fit their domestic policies. Thus, technically, developing countries have the liberty to take advantage of the existing price differences in other countries around the world. However, the usefulness of such provisions is doubted and subjected to debate, as they have not been applied, having at most been used as a

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511 See Article 3 & 4 of TRIPS.
512 See Section 5(d) of the DOHA Health Declaration 2001, as adopted by the Fourth Session of the WTO Ministerial Conference at Doha on 14 November 2001, WT/Min(01)/Dec/W/2.
bargaining chip in negotiations with pharmaceutical companies.\textsuperscript{513} In the next section, we shall turn to the question as to why pricing is of a central importance to the access to drugs.

3. Drugs Prices - Why Does It Matter So?

Underlying all the debates about intellectual property rights and patents on medicines is the basic recognition of an uncomplicated fact – the majority, in fact millions, of the world’s poorest populations could not afford to pay for the cost of treating the infectious diseases that mar their everyday lives. This problem, entrenched in a recipe of social problems, poverty, inadequate public health provision and expensive prices, means that with any further increase in vital medicine prices, the effect will be that more people will be thrown into the same category of those who are already denied adequate access to health care.

In 2004, the world spent a total of US$ 4.1 trillion on health, which is equivalent to 4.9 trillion international dollars (International dollars are used to account for the purchasing power of different national currencies). The geographical distribution of financial resources for health is uneven. There is a 20/90 syndrome in which 30 member countries of the OECD make up less than 20\% of the world’s population but spend 90\% of the world’s resources on health.

It is an irony to note that at the heart of the global health system, financial provision is inversely related to need. Richer countries with smaller populations and lower disease burdens spend more on health resources than poorer countries with larger populations and higher disease burdens.

According to the latest WHO’s World Health Statistics,

“OECD\textsuperscript{514} countries spend a larger share of their gross domestic product on health, spending on average more than 11%, compared with 4.7% for countries in WHO’s African and South-East Asia regions. This translates to per capita spending of about 3080 international dollars (US$ 3170) in OEC countries compared with 102 international dollars (US$ 36) in countries in the African and South-East Asia regions, which are much poorer.

Linking this spending to epidemiology, the figure shows that although poorer WHO regions, such as Africa and South-East Asia, account for the largest share of the global burden of disease (more than 50% of global disability-adjusted life years lost) and 37% of the world’s population, they spend about 2% of global resources on health. The Western Pacific Region, excluding Australia, Japan, New Zealand and the Republic of Korea, accounts for 24% of the world’s population (which is dominated by China), about 18% of the global burden of disease but only 2% of the world’s health resources. The Region of the Americas and the European Region, excluding the OECD countries, account for about 12% of the world’s population, 11% of the global burden of disease and spend slightly less than 5% of health resources.\textsuperscript{515}

\textsuperscript{514} Formally known as ‘Organisation for Economic Co-operation and Development’.

Interestingly, it is also arguable that contrarily, the reason why richer countries with smaller populations have lower disease problems is because they spend a lot more on health. More money spent equals better health. However, this blatantly ignores the fact that in many parts of the world, this is a luxury one can only dream of. As global food prices keep rising and inflation impinges on everyday goods, it will be much more difficult to balance the need to live and the need to be healthy. In the developing world, the affordability of treatment is a function of household income and the cost of medicines.\textsuperscript{516} Poorer households are far more susceptible than richer households to any form of price changes because the same cost will take out a larger share of their income. For these households, spending on medicines may mean a diversion of resources from other essential areas, such as food and education.

In richer countries, health service provision tends to be funded via public expenditure or in some cases through private medical insurance. In the developing world, most people do not have access to medical insurance and they usually have to fund the costs of sickness, which includes buying medicines, from their own pockets. To illustrate, in 2005, general government expenditure on health as a percentage of total health expenditure in Afghanistan is 20\% while in Myanmar the figures show 10.6\%; conversely private expenditure on health as percentage of total expenditure on health in the same countries are extremely high – 80\% for Afghanistan and 89.4\% for Myanmar.\textsuperscript{517} Therefore, patent on medicines can be a double-edge sword. On the one hand, it creates


health, by giving incentives to develop newer and better drugs; on the other hand, it can also impede access due to the comparatively high prices of patented drugs.

With the implementation of TRIPS, it means that areas like biotechnology and pharmaceuticals are fully integrated into the global trade and intellectual property regime. This is a major departure from previous conventions. Traditionally, a number of countries put restrictions on the patentability of drugs based on public policy reasons or provide patents only for production processes rather than products. To many developing countries who either have no patent protection or if they do, only on a partial protection basis, health is a basic need and thus should be protected from full commercialization. A very distinct example is that of India, who characteristically endorsed this position with its strict patent legislation which did not recognize product patents on pharmaceuticals.

The trade/commercial nature of TRIPS holds potential threats to the equitability of access to medicines; which in turn greatly influences the right to health. This is especially dear in the majority of the developing world, where even sometimes the affordability of cheap generic drugs already posed a predicament to those living below the poverty line. Accordingly, the following section explores the role played by the generic drug industries.

4. Generic Drug Industries

India has developed a relatively strong generic drug industry, thanks to the 1970 Patent Law, under which local companies were allowed to copy patented drugs provided that they found a new process. Before 1970, the country was almost entirely dependent on imported drugs. Today, over 70% of pharmaceuticals consumed in the country are locally

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produced. India is also the world’s leading supplier\textsuperscript{519} of inexpensive generic medicines (not only AIDS medicine but also medicines to treat other disease as well), with approximately 67\% of them being exported to developing countries.\textsuperscript{520} India is an important player in the generic drug industry because Indian companies make both the finished generic tablet form of drugs as well as the raw ingredients and chemicals used in their production, most of which is actually exported to big pharmaceutical companies to manufacture their brand-named drugs.\textsuperscript{521}

One of the vital impacts of the Indian Patents Act and the resulting development of a generic pharmaceutical industry is significantly lower prices for drugs compared to other countries. Even though this does not explicitly mean universal access to drugs, it does help foster better access to medicines, not just for its own populations but also for the rest of the developing world. Indeed, a report by Médecins Sans Frontières states that “Globally, 70\% of [ARVS] for 900,000 patients in 87 developing countries, purchased by UNICEF, IDA and the Global Fund (GFATM) since July 2005 had come from Indian suppliers”\textsuperscript{522}. In addition, 75-80\% of all medicines distributed by the International Dispensary Association (IDA) to developing countries are manufactured in India.\textsuperscript{523}

\textsuperscript{519} Leading Indian companies such as Cipla and Ranbaxy are also important exporters.

\textsuperscript{520} Médecins Sans Frontières, ‘Examples of the importance of India as the “Pharmacy of the World”’, (29 January 2007), \url{http://www.accessmed-msf.org/documents/Overview%20Jan%202007%20FINAL.doc}, accessed 7 December 2007.


\textsuperscript{522} Médecins Sans Frontières, ‘Examples of the importance of India as the “Pharmacy of the World”’, (29 January 2007), \url{http://www.accessmed-msf.org/documents/Overview%20Jan%202007%20FINAL.doc}, accessed 7 December 2007.

\textsuperscript{523} IDA is a medical supplier operating on a not-for-profit basis for distribution of essential medicines to developing countries: \emph{Ibid}. 

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However, WTO rules commit India to full implementation of the new intellectual property regime by 2005. In December 2004, India amended its patent law to allow patents on the chemical molecules used in drugs and this applies not only for new drugs but also for many others that were patentable after 1995. Prior to that, India has only allowed patents on the manufacturing processes used to make the drugs and not on the end products themselves. This successful arrangement was designed to encourage companies to compete in low-cost manufacturing, developing the nation’s industry and promoting medicines to be widely available at lower prices. Following the change in India’s patent laws, it is doubtful that this will still be the case and in simpler terms, it means that for the majority of the people, not just in India but also the rest of the developing world, newer AIDS drugs would become more expensive and hence, less accessible or available. Furthermore, the WTO is putting more pressure on all countries to conform to European/US style drug patents and has given ‘least developed’ countries the alternative to extend this deadline to 2016.

Other countries such as Brazil, Argentina, and Thailand have also developed strong local drugs industries under patent regimes which have placed a premium on improving access to essential drugs, rather than on the protection of monopoly rights. In each case, major legislative reforms have now been undertaken to bring domestic legislation into line with WTO rules, often under extreme duress. The US in particular has consistently used the threat of trade sanctions to ensure compliance with the TRIPS regime.


525 Ibid.

4.1 The Influence of the Pharmaceutical Industry in the Issue of Access to Medicines

“The real issue for the multinational corporations is not the poor-country markets, which are financially small and unattractive, but the poor-country examples. How would thousands of people in rich countries, especially the U.S., be persuaded to accept death from cancer and other diseases because they cannot pay tens of thousands of dollars a year for a new generation of treatments that could save their lives - if companies in India could manufacture and sell the same treatments for a small fraction of the price?”

The powerful pharmaceuticals giants have always try to prevent generic competition and oppose endeavours by developing countries to make or obtain cheaper drugs, even though a successful distribution of cheap, generic drugs means more poor people can have access to life-saving drugs. Their motivation ultimately is the protection of their own interests. The industry is worried that erosion of patent rights or prices in one country could lead to similar actions elsewhere, especially in the United States, which is the main source of profits for the industry. The fear of such domino effects on drug prices and patents is reflected in the statement made by Jean-Pierre Garnier, the chief executive of GlaxoSmithKline – a major supplier of AIDS drugs:

“There was a feeling that if a country deliberately went against TRIPS, there would be a castle-of-cards effect...Without patents, the industry ceases to exist.”

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529 Ibid.
Pharmaceutical companies can put pressure on countries or generic drugs producers to influence them to change their policies, even if their actions are in accordance to international law. The interference of the drug companies in the availability of affordable, life-saving medicines for the developing world can be seen in the example of Ghana. In 2000, Glaxo-Wellcome moved to block the importation of generic versions of its premier AIDS drugs, Combivir, into Ghana with threats of lawsuits, arguing that sales of such generic drugs were illegal because they violated company patents.\(^{530}\) In reality, Combivir, which is a combination of two main AIDS drugs – AZT and 3TC, is a very valuable product to Glaxo-Wellcome with total world-wide sales within the $billions mark.

According to Mr. Kiige, head patent examiner of the African Regional Industrial Property Organization, the patents were invalid because at the time they were issued, Ghana did not grant patent protection to pharmaceuticals.\(^{531}\) This meant that Cipla’s and Ghana’s actions were legitimate. However, the pharmaceutical company prevailed in the end. Cipla stopped importing the AIDS drugs to Ghana and Healthcare Ltd (the Ghana distributor) stopped distributing the drugs they had in store because of fear of legal threats. Comparatively, Ghana only represents a tiny fraction of Glaxo’s revenues while the US market alone was worth $478.4 million in 2000. Hence, whilst drug companies worries, that examples of violation of pharmaceutical patents may open a Pandora’s box of similar actions in other countries (which will hurt their profits), Ghana’s AIDS sufferers are helpless as their life-saving drug supply is cut off.


Conversely, some countries such as Thailand are braving the wrath of western governments by invoking compulsory licensing to suspend patents protection held by pharmaceutical giants like Abbott Laboratories, Sanofi-Aventis and Bristol-Myers Squibb. By approving generic production of Kaletra (an advanced HIV/AIDS treatment) and Plavix (a blood thinner), Thailand would be able to dramatically slash their cost to patients by up to 90% and allowing its government to provide treatment to thousands more people. Financial constraints were cited as the main concerns. The Thai ministry of Public Health said that only 20% of around 200,000 affected patients in Thailand were receiving Plavix due to the high cost. Compulsory licensing would cut the cost per tablet from over $2 to as low as 20 cents, permitting doctors to increase patient access to the drug. As for the antiretroviral - Kaletra, although it was already sold by Abbott Laboratories to the Thai government at a substantially discounted rate of USD 2200 per patient per year, generic equivalents could cost USD 1080 or less. Currently, around 120,000 of an estimated 500,000 HIV-positive Thais receive a generic retroviral cocktail produced by a state-owned pharmaceutical company. However, because an increasing number are becoming resistant to this cocktail, more patients would have to be prescribed Kaletra (a second line antiretroviral) in order to survive.

While Thailand’s moves were lauded by humanitarian groups such as Oxfam and Medecins Sans Frontieres (MSF), the pharmaceutical industry was alarmed at this blatant attack on intellectual property, especially when Thailand began pushing to make generics

not only for AIDS drugs, but also for cancer and heart medications as well as antibiotics. With a per capita income of $2,750 a year, Thailand represents a class of nations that could greatly dent the profits of pharmaceutical companies if they succeed in their generic drugs plans and it might serve as an unwelcome example for other countries such as Brazil and Philippines to follow suit.535 Consequently, Abbott announced on 14 March 2007 that it was pulling applications it had pending to register seven new medicines for sale in Thailand.536 Then on 30 April, the Office of the U.S. Trade Representative alluded to Thailand's issuing of compulsory licenses as one reason for elevating the country to the Priority Watch List, a U.S. government warning to countries that it judges do not satisfactorily protect intellectual property, which can drive away foreign investment and impact export tariffs.537 Still, Thailand has refused to cave in to pressures from its detractors, thus confirming its commitment to provide equitable access to health via medicines to the people and putting the lives of the vulnerable ahead of corporate profits. It should be noted that this is in line with international trade rules and the flexibilities allowed under TRIPS, which permits developing countries to use compulsory licensing to seek cheaper generic versions of medicines, when faced with public health emergencies. Thus, it is arguable that the steps taken by various countries, in considering the links between intellectual property rights, drugs’ prices and the access to drugs (which again to be noted, is an integral part of the right to health) when developing their legal and policy framework in the health department, should be seen as positive attempts to fulfill the

537 Ibid.
realization of the right to health. Pharmaceutical products should not be regarded as commodities in the sense of vehicles or electrical goods. Equitable access to drugs is vital for the improvement of public health and also for the realization of an aspect of the right to health; therefore unfair actions by any parties to impede this right is deplorable and safeguards need to be erected in place to ensure a better provision of public health. Nonetheless, the arguments put forward by the pharmaceutical industry would also be discussed.

4.2 The Industry Stance and the Dispelling of Myths

Industry representatives argue that patents are necessary to create incentives to develop new technology and drugs to combat existing and upcoming diseases. As the pharmaceutical industry spends more than any other industry on research & development, companies cannot continue in the business of high-risk, high-failure research without the promise of high profits on a number of successful drugs. In the words of Lee Goldman, chairman of the department of medicine, University of California, “companies translate biological advances into usable products for patients. They do it for a profit motive, but they do it, and it needs to be done.”

Different pharmaceutical companies now run several cost reducing programs to try to ensure better access. For instance, Boehringer-Ingelheim (a German pharmaceutical company) announced its plans to reduce the price of its antiretroviral drug nevirapine, which was sold under the brand name Viramune, by 50% and 90% in low- and middle-income countries, respectively. Accordingly, the drug will cost 60 cents per patient.  

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daily in 78 low-income countries and $1.20 per patient daily in 67 middle-income countries.\footnote{540} However, strong advocates of ‘profits should come before charity’ are likely to tap into the most famous challenges to the idea of corporate philanthropy - Friedman’s ‘Neoclassical’\footnote{541} school of thought. Milton Friedman takes the extreme view that businesses ought not to engage in philanthropy. Charity expenditure goes against a business’ only duty, which is ‘to make as much money as possible while conforming to the basic rules of the society’. According to this view, corporate spending on philanthropy is morally wrong: the money spent does not belong to the executives who decide to spend it, but to its shareholders, customers and employees. Friedman adds that corporations have no political authority to decide what is in society’s best interest. At the end of the day ‘it’s all about profits’.

However, profits earned by the pharmaceutical industry, whether calculated as a percentage of assets or as a percentage of revenues, are among the highest in the corporate world. For example in 2002, in a year when the stock market remained listless and company after company was wounded by accounting scandals, the 10 biggest drug companies profited $35.9 billion – the equivalent to more than half of the $69.6 billion in profits netted by the entire list of Fortune 500 companies.\footnote{542} In 2006, many pharmaceutical companies even beat the top three companies in the Fortune 500 list in terms of greater profits as a percentage of revenues. To illustrate, the profits as a percentage of revenues for Wal-Mart was 3%, Exxon 11% and Chevron 8% in 2006.

\footnote{540} \textit{Ibid.} \\
\footnote{541} This school of thought derived its inspiration from Adam Smith’s ‘Inquiry into the Nature and Source of the Wealth of the Nations’. \\
Conversely, the same year profits as a percentage of revenues for the top three pharmaceutical companies were: Pfizer, 37%; Johnson & Johnson, 21%; and Merck, 20%. Overall, the after-tax median profits of pharmaceutical companies were 9.6%, considerably higher than the median after-tax profit level of 6.3% for the other Fortune 500 companies combined.\(^{543}\)

In addition, the total combined global pharmaceutical sales for 2006 for the top 10 biggest pharmaceutical companies\(^{544}\) is $271.83 billion.\(^{545}\) In the United States, in the first six months following the launch of the new Medicare\(^{546}\) drug program, the ten largest pharmaceutical companies enjoyed substantial profit increases.\(^{547}\) In the first half of 2006, profits for these companies increased 27%, by over $8 billion. Pfizer, the largest pharmaceutical company, saw a 73% profits increase ($2.7 billion); while Merck has a $1 billion profits (44%) increase.\(^{548}\) All these statistics show why pharmaceutical companies always sought to extend the period of patent protection. It also further weakens the myth


\(^{544}\) In receding order: Pfizer; Glaxo Smith Kline; Sanofi-Aventis; Novartis; Astra-Zeneca; Johnson & Johnson; Merck; Roche; Lily; and Wyeth.


\(^{546}\) This is a health insurance program run by the United States government for people aged 65 and above and also those who meet special criteria. In the report by Rep Henry Waxman, analysts predicted that because of the privatized structure of the program and the ban on federal negotiations with drug manufacturers for price discounts, taxpayers and Medicare beneficiaries would be forced to pay high prices for prescription drugs.


\(^{548}\) Ibid.
that pharmaceutical companies, with their high risk involved, need to make more profits in order to survive; and statistics like the above seems to show “a moral and logical need for a fundamental reform as to how the pharmaceutical industry is funded and rewarded”.

Raymond Gilmartin, CEO Merck & Co Ltd, dismissed the impact of patents and their prices as the prime cause of lack of health protection on developing countries. He stated,

“We know that patents are not a significant barrier to access [of patents to medicines], because in many countries in need, patents do not exist … many essential drugs that are required for treatment are available off patents. We have also demonstrated that price alone is not the answer to access. By providing HIV/AIDS medicines at prices from which we make no profit in the world’s poorest countries, we have been able to reach more people but not the millions that are in need.”

By discovering and developing new drugs, the pharmaceutical industry plays a vital role in ensuring that the special objectives of preserving human life and promoting health are met as best as possible. This is why in recent years, public debates and protests surrounding the very commercial nature of the industry and criticisms leveled at the impacts intellectual property rights system has on access to medicine had grown more heated and intense. As R. Bolton, Director of Scientific and Technical Policy, AstraZeneca R&D, observes:

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“It is often judged that medicine is a special area to which society should not apply normal economic rules. The pharmaceutical company is expected to work on targets that will never return an investment, and should not exercise its intellectual property in the same manner as in other manufacturing industries so as to support further employment and growth. It is fully accepted that neither research into rare diseases nor those which occur only in socially or economically deprived societies should be excluded, but the ethical dilemma which society must address is how to fund this innovative activity.”

According to the same report, recent studies on the pharmaceutical market have shown that a company has to introduce every year one new product which sells around £300mn per year for every 1.5% it has of the world pharmaceutical market – if the company is to sustain average industry growth. The obvious dilemma in this scenario is between the pharmaceutical industry’s fundamental mission to ease suffering, and the need to also stay in business. From the former perspective, health needs of the people ought to be a priority that overrides profits. As for the latter, this will cause a different set of priorities, which may well divert the full attention of the industry away from its perceived obligations to meet health needs.

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552 Ibid.
It is arguable that a system that only relies on patent protection to stimulate innovation can easily run the risk of becoming distorted and inefficient. Critics argue that in the past two decades, breakthrough in therapeutic innovation is minor. Indeed, it appears that one of the main outputs of pharmaceutical companies is duplicative rather than breakthrough in nature. For example, the antacid Nexium was AstraZeneca’s virtually identical replacement for Prilosec when its exclusive rights on the older drug expired. In the drug category of painkillers, Ibuprofen constitutes 29% of the market but 20 other similar drugs are also marketed such as Celebrex and Mobic. It is interesting to note that most of the drugs mentioned are more likely to be convenience/lifestyle drugs instead of the therapeutic drugs desperately needed to cure many life-threatening diseases of the developing world. This in a way illustrates how access to medicine is never the same between a person living in the Western world and a person living in the slums of a poor country. Thus, it is arguable that the injustice of patent introduction in developing countries and the profit-oriented nature of the pharmaceutical industry have grave impacts on the right to health of many people – the majority of which reside in developing countries. In the period from 1998 through 2003, out of the 487 drugs approved by the US Food and Drug Administration (FDA), 379 (78%) were classified by the agency as “appear[ing] to have therapeutic qualities similar to those of one or more already marketed drugs,” and 333 (68%) were not even new compounds (what the FDA

555 In a chart showing five categories of drug (antidepressants, painkillers, cholesterol drugs (Statins), sleeping pills and heartburn drugs), there is certainly no lack of treatments available i.e. many different drugs are marketed to cure the same ailment. Langreth, Robert and Matthew Herper, ‘Pill Pushers: How the Drug Industry Abandoned Science for Salesmanship’, (5 August 2006) http://members.forbes.com/forbes/2006/0508/094a.html, accessed 7 September 2007.
calls “new molecular entities”), but instead were new formulations or combinations of old ones.\textsuperscript{556} Only 67 (14\%) of the 487 were actually new compounds considered likely to be improvements over older drugs.

Critics also pointed out the issue of the huge expenditures incurred as a result of advertising and marketing. An article by Forbes states:

“The top ten drug firms invest $42 billion a year on research, 14\% of sales - yet they plow more than twice that much into marketing and administration. In a decade drug firms have almost tripled the ranks of salespeople calling on physicians, to 100,000, according to Verispan. That's one seller for every 9 doctors; in 1996 it was one for 18. Often they encourage unauthorized off-label uses or sponsor "continuing medical education" sessions to stoke more prescriptions and broaden a drug's patient base.”\textsuperscript{557}

A lot of marketing is needed to persuade a consumer to choose one duplicative drug over another, whereas a uniquely vital drug will require very little promotion. Besides, drug companies nowadays try to promote diseases to fit drugs, rather than the reverse. They try to persuade people in well-off countries that they are suffering from conditions that need long-term treatment. Consequently, millions of normal people come to believe that they have doubtful or exaggerated ailments such as “generalized anxiety disorder,” “erectile dysfunction,” or “premenstrual dysphoric disorder”\textsuperscript{558} – ‘health’ problems many have not


even heard of in developing countries. This phenomenon is worrying because it means diverting research and development of drugs from areas where they are especially crucial (such as malaria and tuberculosis) and reaffirming the criticism that poor countries do not provide sufficient profit potential to attract research and development investment by the pharmaceutical industry. This will lead to further decline of the health of the poor, which also means that their human right to health has been neglected.

So far, evidence seems to suggest that the prices set for drugs reflect less the actual cost of research and development, but rather more the corporate expenditure associated with marketing, lobbying and advertising. This raises the question as to how much of the proceeds from patents actually find its way into socially-beneficial research.

Only history will tell us who has benefited and who has suffered from the WTO agreements, but some countries today are doing their best to apply the WTO agreements as little and as late as possible. It is in their own interests to take advantage of the maximum implementation delays granted to them, even if only to have the time to look at all the possible means of attenuating the negative effects of the WTO agreements. In this respect, the fact that Western pharmaceutical firms are insisting that the countries concerned cut short the grace period to which they are entitled speaks volumes. This period of reflection is all the more important as these countries will be unable to backtrack once the new legislation enforcing the TRIPS agreement is in place, even if their grace period has still not fully elapsed.

To relate back to the previous chapter on globalization, the obstacles placed against developing countries show that it is still far too easy for powerful countries like the United States to set the terms of global agreements and to ignore those terms when they
pose inconveniences. The same applies to the large multinational companies who put aside all considerations in their quest for mega-profits. The relationship between patent protection and the human right to health is all too often easily brushed aside by advocates of the intellectual property rights system. Globalization is not an equalizing phenomenon and it is vital we recognize the link between this phenomenon, patent protection, access to medicines and ultimately the right to health. The right to health is hard to fulfill not merely because it is framed vaguely in the ICESR but also because of such impediments to equitable access to medicines.


In 1997, the South African government passed the Medicines and Related Substances Amendment Act, giving it authorization for both compulsory licensing and parallel imports - a move which is completely legal under TRIPS. As a legacy of apartheid and the combined result of pressure from countries like the United States, South Africa has a strong patent system. However, in Africa, approximately one in five adults are living with HIV/AIDS, and no one except the extremely rich can afford to buy medicine. This coupled with the high costs of antiretroviral ($15,000 per annum in the United States whereas it is about $200 in India where there is no patent protection) means that making these treatment universal, would have crippled the government financially. Thus, it is


reasonable for the South African government to pass a law which would bring the drug prices down.

As a response to that, the world’s major pharmaceutical companies and the South African Pharmaceutical Manufacturers Association brought a lawsuit against the South Africa government in the Pretoria High Court. The pharmaceutical industry fears that if cheap generic drugs become widely available in poor countries, they could 'leak' back to industrialised countries. They see themselves as 'scapegoats' when the central problems are mostly related to the lack of resources, infrastructure and political will of the developing countries. Basically, the pharmaceutical companies feel that the industry would suffer profit-wise due to the potential examples set by the generic drug industry.

The Amendment Act of 1997 provides a legal framework to increase the availability of affordable drugs in South Africa. Provisions included the generic substitution of off-patent drugs, transparent pricing for all medicines, and the parallel importation of patented drugs. Clause 15 (c) states that:

“… The Minister may prescribe conditions for the supply of more affordable medicines in certain circumstances so as to protect the health of the public, and in particular may… prescribe the conditions on which any

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562 There are forty-two applicants representing a host of multinational and South African drug companies as well as South African subsidiaries of multinational pharmaceutical companies. There are ten respondents in this case. The first respondent is the former President of South Africa, Nelson Mandela. The fourth respondent is Dr. N.C. Dlamini Zuma, South Africa's Minister of Health.


medicine which is identical in composition, meets the same equality standard and is intended to have the same proprietary name as that of another medicine already registered in the Republic ... may be imported.”

The applicants declared that this clause was unconstitutional – for instance, “... it enables and authorises the Fourth Respondent, in conflict with Section 25 of the Constitution, to deprive owners of intellectual property in respect of pharmaceutical products of such property, alternatively to expropriate such property without any provision for compensation to be paid in respect thereof”; and that it is “discriminatory in respect of the enjoyment of patent rights in the pharmaceutical field which discrimination is in conflict with the provisions of Article 27” of TRIPS. However, it is arguable that this is not supported or, at best only weakly supported by a close reading of the TRIPS Agreement. This is even more ironic when considering the fact that the US government has also used the threat of buying generic alternatives for Cipro, an anthrax medicine, during the time when the States experienced a 'scare' in relation to the above mentioned toxin.

At the start of the litigation, the pharmaceutical companies had the support of their home governments. South Africa was put on the US trade Special 301 Watch List, and was

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567 See Pharmaceutical Manufacturers’ Association of South Africa v President of the Republic of South Africa, Case No 4184/98 (18 February 1998)
568 Ibid.
569 See sections 2.2 and 2.3 of present chapter about the exceptions and limitations of TRIPS
threatened with further trade sanctions and withholding of trade benefits. However, the legal issues underlying the lawsuit were never heard because a global coalition was formed in support of the South African government and due to the avalanche of relentless public negativity and international public outrage, the US had to bow to pressures and ended trade pressures. Trying to stave off a public relations disaster, some of the largest pharmaceutical companies began offering new discounts to South Africa and other poor countries. On 1 December 2000, Pfizer agreed to donate Fluconazole to the public health agencies of South Africa; Boehringer Ingelheim offered Nevirapine free (albeit exclusively for the prevention of mother-to-infant transmission of HIV) and, between April 2000 and April 2001, the per patient cost of one year of triple drug antiretroviral therapy dropped from $3000 to $1000.571

Finally after three years of delays and counter-delays, the pharmaceutical companies decided to unconditionally drop the lawsuit572 against the South African government on the 19 April 2001.573 This much publicized case brought stronger attention to the impact intellectual property rights has on the access to health, but in the period of delay, 400,000 people have died of AIDS-related illnesses.574 Nonetheless, Ellen t’Hoen575 is of the view that this court case finally brought two key issues into the international arena. Firstly,

clarification is needed in the interpretation of the flexibilities of TRIPS and their use for public health purposes. (This is to ensure that developing countries could use the relevant TRIPS provisions without the threat of legal or political challenge.) Secondly, it shows that industrialized countries which used trade pressures to defend the interests of their multinational industries could no longer do so without having political repercussions at home, manifesting themselves in a public loss of trust. Another interesting development in access to health and medicines is the example of Brazil.

Brazil is an example of a country which has offered comprehensive AIDS care including universal access to antiretroviral treatment since the mid-1990s. The pillar to the success of Brazil’s AIDS program is its ability to manufacture its own cheaper copies of patented drugs. Its price for an AZT equivalent was down from $15,000 to $4,000. This ability was in turn due to the fact that Brazil did not adopt pharmaceutical patents until it joined the WTO in 1997. It was therefore legal to produce equivalents of expensive medicines patented before that date in the industrialized countries, or import them from India, which also did not have patenting on pharmaceutical products. Both countries were obliged by the WTO TRIPS Agreement to have national legislation in place by 2005 which provides patent terms of at least 20 years for all products and processes. The fact that Brazil met this requirement nearly a decade earlier is evidence of the intensity of the pressures from developed countries, especially the US’s economic and political pressures, including the use of trade sanctions, although it also reflects a weak commitment on the part of the Brazilian government to a more independent economic development strategy.

Nonetheless the health successes of the AIDS program should be noted. The country’s impressive achievements since 1996 include halving the mortality rate, an 80 per cent fall in the hospitalisation rate, and a sharp reduction in mother-to-child transmission. The incidence of HIV is now considerably lower than earlier UN predictions of millions of cases and by 1999, this supply strategy had knocked 70% off treatment costs, enabling the health service to treat three times as many people for the same outlay and saving tens of thousands of lives.\textsuperscript{578} Programs such as those run by the Brazilian government are a good example for other developing countries that are able to manufacture medicines locally, and by offering to cooperate in the transfer of technology, Brazil’s example encourages other developing countries to find their own viable ways to deal with the rising costs of drugs and to fight off diseases suffered by their people. This is commendable because it is a step towards the realization of the right to health, through the access to medicines.

However, the pharmaceutical industry was outraged and directly challenged the Brazilian government over its drug policies, accusing it of strict price control and for not respecting intellectual property rights. This is quite similar to the case of South Africa mentioned earlier. In February 2001, the US also issued a complaint through the WTO’s dispute settlement body, claiming that Brazil’s production of HIV/AIDS generic drugs are breaking international patent law.\textsuperscript{579} Under Article 68 of the Brazil Patent Law, patents are not honoured in the country if the holder of the patent does not manufacture the product locally. Failure to fulfill this requirement after three years will result in the patent

\textsuperscript{578} Ibid.
being subjected to compulsory licensing, unless the patent holder can show that it is not economically feasible to produce in Brazil or can otherwise show that the requirement to produce locally is not reasonable.\textsuperscript{580}

Article 68, paragraph 1 of the Patent Law provides that the following conditions will allow compulsory licensing:

“\begin{enumerate}
\item Non-exploitation of the subject matter or the patent in the territory of Brazil, by lack of manufacture or incomplete manufacture of the product or, furthermore, by lack of complete use of a patented process, except in the case of non-exploitation due to economic unfeasibility, when importation will be permitted; or
\item Commercialization that does not meet the market needs.\textsuperscript{581}
\end{enumerate}

The US government asserted that the Brazil Patent Law discriminates against US holders of Brazilian patents and that it does not comply with the TRIPS Agreement. The Brazilian government argued that US intellectual property lawyers were disregarding the fact that Brazil's provision for local manufacture of a patented product was a safeguard which can be invoked only in a case of 'abuse of rights or economic power' by a patent holder, and, as such, it is not a violation of TRIPS.\textsuperscript{582} Another argument was that Article 68 was in line with the text and the spirit of TRIPS (including Article 5.4 of the Paris


Convention, which permits compulsory licensing if there is a failure to work a patent).\textsuperscript{583} Article 2.1 of TRIPS also incorporates relevant articles of the Paris Convention. International campaigns were waged against this perceived injustice perpetrated upon Brazil, which would consequently lead to detrimental impacts on Brazil’s commendable AIDS program. As a result of intense public outcry and protests, the US, in a joint statement with Brazil on the 25 June 2001, announced that it would withdraw the WTO panel complaints against Brazil. As a resolution, the two countries agreed to cooperate regarding the shared goals of combating AIDS and protecting intellectual property rights. Protests had focused not only on the pharmaceutical industry and the US government, but also on leaders of some developing countries and their ministries of health. Heywood points out that developing countries constantly misuse even the limited resources they have, often in an attempt to compete with their western counterparts.\textsuperscript{584} The South African government spent $4 billion on re-armament, despite no immediate threats from its neighbours, at the same time, it was also arguing that it lacks the resources to expand access to voluntary HIV counseling and testing services.\textsuperscript{585} Barnard is of the view that it is tempting to attribute the disappointing results of South Africa’s legal victory against the pharmaceutical industry to a failure of political will.\textsuperscript{586} President Mbeki’s widely quoted skepticism about the causal connection between HIVS and AIDS and the Ministry


\textsuperscript{585} Ibid.


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of Health’s frequently reiterated refusal to increase ARV treatment despite its legal victory, further supports this interpretation.\textsuperscript{587}

5.1 Facts of \textit{Treatment Action Campaign v. Minister of Health, High Court of South Africa}

In August 2001, the Treatment Action Campaign (TAC) brought a suit\textsuperscript{588} against the South African government itself, contending two issues\textsuperscript{589}: firstly, the state must make Nevirapine (a registered drug) available to women who have HIV and give birth in the public health sector, to reduce the risk of HIV transmission to their babies, if the doctor or attending nurse feels this is necessary. Secondly, the state is obliged to implement and set out clear time-frames for a national programme to prevent mother-to-child transmission of HIV, including voluntary counselling and testing, antiretroviral therapy and the option of using formula milk for feeding. The government failure to do these is an infringement of the right to health of HIV-positive women and their children as guaranteed in the South African Constitution. National cases like this are important to the international legal discourse on the right to health, because they often provide an insight into how the right operates at the local level.

The South African government justified its refusal to make Nevirapine generally available in public clinics by arguing that the drug’s safety and efficacy had not been satisfactorily established and that it was of limited benefit in a breast-feeding population

\textsuperscript{587} \textit{Ibid.}


(that the statistics showing infants acquiring HIV from breast-feeding would be almost as big as the number infected in the absence of preventive treatment with Nevirapine).

Nevertheless, the Medicines Control Council - a body with the statutory duty to investigate whether medicines are suitable for the purposes they are intended, plus the safety, quality and therapeutic efficacy of medicines - has registered Nevirapine for use to reduce the risk of mother-to-child transmission of HIV. This means that Nevirapine has been approved to be suitable for this purpose. A study based on a randomized controlled trial in Uganda had shown that Nevirapine achieves a similar reduction of transmission in a single dose compared with other antiretroviral treatment.

Notwithstanding this, the Department of Health has laid down a policy limiting the availability of Nevirapine by designating two sites per province where pregnant HIV positive mothers may be administered the drug. The result is that outside of the designated sites, Nevirapine may not be prescribed, even where in the opinion of the treating doctor, this is medically desirable, and even though Boehringer Ingelheim, the manufacturer of the drug, had agreed to make it free of charge for a five year period. However, the government policy regarding Nevirapine is only restricted to the public health sector, as the prescription of Nevirapine in the private sector is not prohibited. In effect, this means that the rest of the unfortunate patients who are forced to use the public health care system due to financial hardships or geographical location are denied access.

591 The study compared the use of a maternal single 200mg oral dose of Nevirapine during labour and an infant 2mg/kg dose of Nevirapine within 72 hours of birth, with a maternal 600mg oral dose of AZT at onset of labour and 300mg orally every 3 hours during labour, with an infant 4mg/kg twice daily dose of AZT for 7 days after birth.
to medication which offers real hope of reducing the risk of mother-to-child transmission of HIV and thereby saving the lives of their children.

The High Court granted the judgment in favour of the applicants, ruling that the government’s policy “in prohibiting the use of Nevirapine outside the pilot sites in the public health sector is not reasonable and that it is an unjustifiable barrier to the progressive realization of the right to health care … a breach of their negative obligation to desist from impairing the right to health care”\textsuperscript{593}, and that it is in breach of Article 27 of the South African Constitution on the fundamental rights to access to health care services, including reproductive health care. As Article 27(2) of the Constitution obliges States to take reasonable measures to achieve the progressive realization of the right to health care, Botha J ordered the respondents to make Nevirapine available on a much wider scale, and to plan an effective comprehensive national programme to prevent or reduce the mother-to-child transmission of HIV.

However, the story does not end here. The government appealed to the Constitutional Court, thus freezing the execution of the High Court order. On 11 March 2001, the judge then granted TAC interim relief pending the Constitutional Court judgment, where the State must provide Nevirapine to doctors in the public sector who prescribe it after voluntary counseling and testing has been offered.\textsuperscript{594} The government then made an unsuccessful interim application to the Constitutional Court to stay the High Court order pending the determination of the appeal. In view of the urgency of the matter, it was

\textsuperscript{593} \textit{Treatment Action Campaign v. Minister of Health, High Court of South Africa, Transvaal Provincial Div., 2002 (4) BCLR 356(T), 12 December 2001.}

given priority and set down for hearing by the Constitutional Court which handed down its judgment on 5 July 2002.

The Constitutional Court identified two issues to be addressed: Firstly, whether the government’s actions of restricting Nevirapine treatment to two government hospitals per province is unreasonable, when measured against the Constitution, namely Article 27 and 28, which gives the right to have access to public health care system and the right of children to be afforded special protection. Secondly, whether the government is constitutionally obliged and had to be ordered forthwith to plan and implement an effective, comprehensive and progressive programme for the prevention of mother-to-child transmission of HIV throughout the country.

5.1.1 Decision of the Case

On the first issue, the court decided that the prevailing government policy was flawed and violated its obligations to provide access to health for all citizens. The court ordered the government to abandon that policy and ensure that Nevirapine was available beyond the two sites for each province. On the second issue, the court found that the government had a constitutional obligation to provide a comprehensive policy to combat mother-to-child HIV transmission and that it had failed to meet that obligation. Allowing the government some room to manoeuvre, the court ordered the government to formulate a programme to meet this obligation. Although the court formulated a fresh order to meet the

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596 “27(1) Everyone has the right to have access to – (a) health care services, including reproductive health care; . . . . (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. . . . .

28(1) Every child has the right –. . . . (c) to basic nutrition, shelter, basic health care services and social services”.
circumstances, it essentially upheld the judgment of the Pretoria High Court, meaning that TAC and others were successful.

One of the issues faced by the court was the enforcement of socio-economic rights; and the present case constituted the third case to be heard along these lines. On the previous occasions, it was recognised that the state is under a constitutional duty to comply with the positive obligations imposed on it by sections 26 and 27 of the Constitution. *Soobramoney v. Minister of Health* concerned S, a 41 year old man, who had chronic kidney failure which was terminal. However, costly dialysis treatment would have prolonged his life for a short period but he was refused treatment because the renal-dialysis unit in the region where he lived had insufficient dialysis machines and had a policy of accepting only patients with acute renal failure. In his claim, S relied on s 27(3) (protecting the right to emergency medical treatment construed with the right to life) as guaranteeing him a right to cost-free medical treatment. In considering whether the Constitution required the health department to provide a sufficient number of machines to offer dialysis to everyone whose life could be saved by it, the Court found no breach under the Constitution since, within the context of the limited resources available, the Health Authority had acted reasonably and applied its guidelines rationally and fairly in the case of S given (a) the expensive nature of the treatment and (b) the fact that it would only have prolonged S’s life for a short period.

597 See *Soobramoney v Minister of Health, KwaZulu-Natal*, 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696 (CC); *Government of the Republic of South Africa and Others v Grootboom and Others*, 2001 (1) SA 46 (CC); 2000 (11) BCLR 1169 (CC).

598 1997 (12) BCLR 1696 (CC)


In *Grootboom*\(^{601}\) the claim was upheld because the state’s housing policy in the area of the Cape Metropolitan Council failed to make reasonable provision within available resources for people in that area who had no access to land and no roof over their heads and who were living in intolerable conditions. Similar to the earlier case, the Constitutional Court determined that although the state is obliged to act positively to ameliorate the conditions of the homeless, it is not under any obligation to go beyond the available resources or to realize the rights immediately. Nonetheless, the court also noted that there is, at the very least, a negative obligation on the state and all other entities and persons to refrain from preventing or impairing the right of access to adequate housing.\(^{602}\)

The significance of these decisions is that the justiciability of socio-economic rights is already an established point, and the present case on Nevirapine further served to cement that position. For so long it has appeared as if civil and political rights enjoy greater protection and more attention than socio-economic rights to the extent that the latter, which are also referred to as “second generation rights”, have the appearance of being “softer”. This case reinforces the position that a violation of socio-economic rights is just as grave as a violation of civil and political rights, and States can be called to account for their conduct.\(^{603}\)

Victims can be assured that when they take action against the government when it fails to advance their socio-economic rights, they will receive serious judicial attention. The court plays a key role as a bulwark not only to prevent the state from abusing its power but also ordering the state to take positive action to advance the rights of citizens. Governments will have to take heed and ensure that they provide access

\(^{601}\) *Government of the Republic of South Africa and Others v Grootbroom and Others*, 2000 (11) BCLR 1169 (CC).


for the enjoyment of these rights. In the context that it deals positively with socio-
economic rights, the case enriches the growing jurisprudence on the enforcement of
socio-economic rights and further strengthens the calls that the right to health is as
important as any other rights in the Bill of Rights. Continuing along the same veins, the
next case to be mentioned in the following section will further highlight the trials and
tribulations of the Indian generic drug industry and its fight to fulfill the right to health of
the people.

5.2 The case of Novartis against India: Novartis AG, Switzerland v Cancer Patients Aid
Association, India

India, with its background of a sizeable generic drug industry, is always under the
international spotlight because of its rub-offs with the pharmaceutical companies. Prior to
the implementation of its patent laws to conform with WTO’s standards in 2005 (and
even until today, although with significantly more restraints), India had developed a
world-class generic-drug-manufacturing sector, creating major generics firms such as
Ranbaxy, Cipla, and Dr. Reddy's, in addition to hundreds of smaller firms.\footnote{604} As Mueller
provides,

“India boasts more drug-manufacturing facilities that have been approved
by the U.S. Food and Drug Administration than any country other than the
United States. Indian generics companies, for instance, supply 84% of the
AIDS drugs that Doctors without Borders uses to treat 60,000 patients in
more than 30 countries.”\footnote{605}

\footnote{604} Mueller, Janice, ‘Taking TRIPS to India- Novartis, Patent Law, and Access to Medicines’, (8
February 2007),
http://www.thecommonwealth.org/news/159354/159818/taking_trips_to_india___novartis___pate

\footnote{605} Ibid.
Nonetheless, in May 2006, Novartis (the Swiss pharmaceutical company) filed a petition in the Chennai High Court accusing the Indian government for failure in complying with the WTO trade rules and TRIPS - with its refusal to grant the company a patent on its leukemia drug called Glivec. Novartis challenged the order of the Chennai patent controller as well as the validity of Section 3(d) of the Indian Patent Act in accordance with the TRIPS Agreement.

When Novartis originally filed the application for the patent, it argued that the present invention involved two-fold progress over the previous one: firstly, the imatinib free base has been chemically changed into a salt form; and secondly, a particular crystal form of the salt has been made through human intervention.\(^{606}\) Besides, there is neither an example for the preparation of imatinib mesylate in the 1993 Patent publication nor any claim therefor. However, the Indian Cancer Patients’ Aid Association launched an opposition against the granting of the patent, and managed to prove successfully that the supposed invention had already been disclosed in the European Patent publication, published on October 6, 1993, and equivalently in the United States.\(^{607}\) Novartis’s patent application was subsequently denied on the grounds that the drug was not innovative enough, but was rather a newer version of an old drug, and therefore was not patentable under Indian law. Besides, generic versions of the same molecule were already available in India.

Nonetheless, Novartis persisted in its challenge of the India’s Patent Law by taking the cases to the Chennai High Court. In essence, the crux of the case was on how drug


\(^{607}\) Ibid.
innovation occurs and whether minor differences in medicines, such as ‘incremental innovation’, require new patents for the drugs.

While India had made some amendments to its patent law in 2005 due to WTO’s pressures, a number of safeguards were built into the new patent law to reduce the impact of medicines patents on the people’s access to affordable medicines. Patents of pharmaceutical products are relatively strict and limited. For example, if the generic enterprises had begun to manufacture a drug prior to the first day of January 2005 and the drug was subsequently covered by an Indian patent, they can continue to make and sell that drug and the patent-holder shall only be entitled to reasonable royalties. Another safeguard is the “opposition proceedings” in the patent law which could be widely used by NGOs or patient advocacy groups to contest the granting of patents. However, the most controversial safeguard of the Indian Patent Law strictly ensures that only truly innovative developments are patentable and this was challenged by Novartis. Section 3(d) elaborates what is not patentable:

“the mere discovery of a new form of a known substance which does not result in the enhancement of the known efficacy of that substance or the mere discovery of any new property or new use for a known substance or of the mere use of a known process, machine or apparatus unless such known process results in a new product or employs at least one new reactant.”

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608 See Section 4.1 of current Chapter.
610 See Sections 22-23 as to the grounds “any person may, in writing”, show his or her opposition to the controller against the grant of patent [where an application for a patent has been published but a patent has not been granted]”, Ibid.
611 Ibid.
Basically, the above-mentioned section prevents spin-off forms of known substances (for instance salts, esters, ethers, polymorphs, metabolites, particle size, isomers, mixtures of isomers and complexes)\textsuperscript{612} from being patentable unless they are significantly more effective than the known substance.

On this basis, Novartis’s application for patent was rejected and this was seen as a triumphant relief for thousands of cancer patients as it stopped a patent monopoly until 2018. Accordingly, the High Court in Chennai made a landmark decision to uphold the India’s Patents Act and dismissed all of Novartis’s claims in August 2007. As for the issue of deciding whether India is in compliance with WTO’s rules and the TRIPS Agreement, the court held that this was a matter for the WTO to resolve. This means that Novartis is unable to take the case any further as only member states can bring trade dispute issues to the WTO disciplinary committee.\textsuperscript{613}

5.2.1 The significance of the Case

The ruling of India High Court against the Swiss pharmaceutical giant Novartis has far-reaching consequences. It helped preserve India’s position as the pharmacy of the world’s poor and served as an impetus for other developing countries to adopt similar rules to protect access to medicines and accordingly the human right to health.\textsuperscript{614}

It is arguable that if Novartis had won the lawsuit, it would have significant impacts on the right to health especially in the context of access to essential drugs of those living in the developing world. Firstly if Novartis successfully argues that drugs such as Glivec are worthy of an Indian patent, then many of the drugs currently produced by the generic

\textsuperscript{612} Ibid.


producers in India for export to developing countries may become patent protected and their production halted.615 Secondly, if Novartis successfully argues that public health provisions are secondary to India's TRIPS obligations, this may place the very existence of the generics industry in jeopardy.616

In fact, India is an important player in the generic drugs industry, not just in the domestic market but also in many developing countries.617 A court ruling favouring a pharmaceutical giant could result in India’s inability to supply the developing world with affordable essential drugs, further imperiling the health of the people. This is especially crucial with regards to HIV/AIDS drugs. Data from the MSF’s project in Khayelitsha, South Africa demonstrates the increasing need for generic drugs to keep medicine prices affordable continuously as people become resistant to HIV/AIDS drug combinations they consume after a certain amount of time.618 It was reported that 17.4% of people in Khayelitsha had to switch to a newer drug combination after five years on treatment.619 New drugs need to be constantly developed to combat the HIV/AIDS pandemic, and as the new drugs are usually available from the pharmaceutical companies, which held the original patent rights, this occasionally creates financial barriers for people to access the necessary life-saving drugs due to high prices and low availability. The generic drug industry serves as competitor to keep prices affordable and also to provide alternative to the people who need the essential medicines.

616 Ibid.
617 See Section 4.1 of this Chapter.
619 Ibid.
The court case also brings to light the power of public persuasion and the role played by NGOs in defending access to medicines and the upholding of the human right to health. About a quarter of a million people from 150 countries had signed a MSF’s petition urging Novartis to drop its lawsuit against the Indian government.\(^\text{620}\) Public pressure has the power to sway policies that might disadvantage the realization of the right to health from happening as seen in the support given by government officials in urging Novartis to drop its lawsuit.\(^\text{621}\) Although Novartis subsequently still continued with the court case (and lost), this showed growing awareness around the world about the importance of access to the right to health and it also highlighted the possible detrimental consequences of WTO and the pharmaceutical industry’s policies on the health of the people.


6. Conclusion

This chapter essentially highlights the access to essential medicines, which is an undeniably imperative factor in ensuring the enjoyment of the right to life and the right to health. The AIDS/HIV pandemic has also brought attention to the importance of the access to drugs issue, as seen in most court cases concerning AIDS/HIVS patients in Chapter Two as well as the South Africa and Brazil scenarios. The WHO’s vision is to ensure that people everywhere have access to the essential medicines they need; that the medicines are safe, effective, and of good quality; and prescribed and used rationally. Accordingly, efforts are increasingly improved in the international community to combat diseases and pandemics and to ensure better access to the right to health.

However, in many parts of the world, countless people are still encountering barriers in accessing necessary medicines and the amount of people dying from illnesses (due to inability to have the proper medical treatment) everyday is staggering. In view of this, this chapter draws attention to the role played by the generic drug industries and the challenges faced by developing countries in combating diseases, particularly when relying on the exceptions provided by the TRIPS Agreement.

Perhaps what is required ideally is a balance between the need to ensure the protection and implementation of the human right to health (which includes equitable access to medicines) and the interests of the pharmaceutical industry, while ensuring at the same time encouraging advancements in the Research and Development of indispensable medicines. According to the WHO, target 8E of the Millennium Development Goals recognizes the need to improve the availability of affordable medicines for the world’s
poor, and this should be done in cooperation with pharmaceutical companies. As Joseph succinctly describes the balancing of interests for the betterment of health, "It is [the] interest [of sick people in obtaining access to essential medicines], which corresponds with [the] human rights to life and health, which is paramount. Interest [in cultivating an optimum level of beneficial pharmaceutical R&D] is functionally important as it is necessary to facilitate the previous interest. Interest [of the pharmaceutical giants and its shareholders in making money] is important from a human rights perspective to the extent that it facilitates interest of promoting R&D, which in turn benefits the interest of those needing access to essential drugs." Human rights language is a crucial force in promoting the health concerns of the people, especially those in the developing world, and despite challenges in projecting a stronger image as a tool of enforcement internationally, the notion and the values that come with it should not be dismissed. In balancing the interests of the various parties in the global issue of access to medicines and the promotion of human rights, it is arguable that all countries should make sure that their global trade policies do not impede on the access of essential drugs, and policies that push for putting public health concerns first before intellectual property rights should be applauded.

Conclusion

In the introduction, the question was raised as to whether we are progressing towards a universal acknowledgment of the human right to health. Following that, what does the right to health encompass under international law, and what are the developments as regards this human right in view of globalization?

Are we moving towards a universal recognition of the human right to health?

The right to health falls under the rubric of economic, social and cultural entitlements within human rights law. With the founding of the WHO, which promulgated “the enjoyment of the highest attainable standard of health” as “one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition” in its Constitution, the right to health was recognized internationally for the first time. This recognition was further reiterated in several international and regional human rights instruments such as the UDHR and the ICESCR as discussed in Chapter One. Health as a human right is increasingly being used as a focal point of discussions in international conferences, meetings and councils. This highlights the growing importance of the synergy between global health and human rights in addressing pressing social injustices in today’s globalized world. Thus, it is arguable that human rights are changing from a narrow, legalistic focus on civil and political rights to a broader rights approach encompassing economic, social and cultural rights.

The delineation between the two set of human rights (civil and political, and economic, social and cultural rights) has always been a point of contention by the liberal consensus

to challenge the universality of economic, social and cultural rights (and accordingly the right to health) and that they are merely legal aspirations. However, as demonstrated in Chapter One, arguments against the right to health as a legal entitlement are flawed and there is plenty of scope to dispel the allegation that only civil and political rights are universal human rights. Appeals to the interdependence of all human rights, the significance of the right to health in global health and international law, as well as the fallacy of the liberal claims are key points of leverage.

Chapter One points to the interdependence of human rights and that no one can fully enjoy any right, even civil and political rights, if they do not have the necessary essentials for a healthy and decent life. This is a key point that is often overlooked in contemporary human rights dialogue and practice. Statistics mentioned throughout the thesis indicate the seriousness and burdens of diseases and ill-health and Chapter Three considered the importance of health and how the complexities in global health can affect other human rights as well. As the right to health encompasses more than just health care, it is reasonable to argue that without access to decent levels of minimum income, housing, education and health, individuals are placed in a vulnerable state which may then be susceptible to any threats to the integrity of civil and political rights. Furthermore, with the enshrinement of the right to health in numerous international law treaties and documents, the notion of the human right to health has gained a level of credence towards being a recognized right on an universal scale. It also furthers understanding of the duties and responsibilities of States Parties to advance the enjoyment of this entitlement considered to be a right of each human.
Case law provide further evidence that the human right to health is gaining worldwide recognition. States around the world have an obligation under international treaties and national constitutions to respect, to protect and to fulfill the right to health. While it is true that the necessary mechanisms in place to ensure such compliance are less than those for civil and political human rights, it does not mean that their continued articulation in human rights discourse is futile. Chapters Two and Four illustrate the frequency with which courts are more willing to found their decisions on the internationally known human right to health. They emphasized how the number of cases regarding the right to health are escalating, especially with regards the AIDS/HIV pandemic in the developing world. The chapters described the courts’ role in implementing the human right to health and in ensuring that those in need have the essential access to medical treatments as well as to ensure that the necessary social conditions relevant to the realization of the right to health are in place. Court cases also served to highlight the interdependence of human rights, such as the relationship between the right to life and the right to health. Such health based litigation has drawn the world’s attention to the importance of global health and the chasms in society in accessing health care. Growing interest in economic, social and cultural rights litigation is vital. It shows the constructive potential of law and human rights norms in propagating positive changes in social health policies, not just domestically but also internationally.

Universal recognition of the human right to health will increasingly be an important evaluation of governments’ abilities and compliance around the globe to balance human rights and global health governance. Based on the discussion in the preceding chapters, it
can be argued that we are on the pathway towards a universal recognition of the human right to health.

What does the right to health entail under international law?

To make the human right to health a valid and universal human right rather than a mere aspiration, it is important to have an understanding as to what does this right include. The WHO Constitution defines health as a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” and this is the most universally known and used in the right to health framework. Chapter One in part addressed the scepticism regarding the possibility of defining strictly a word such as ‘health’ and the arguments concerning the vagueness of the WHO definition of health. As reiterated in Chapters One and Two, the human right to health does not mean a guarantee of perfect health or the right to be healthy, as the state of being healthy is an indeterminate variable shaped in part by health care, but also by genetic predisposition and social factors. WHO definition, which tried to put health in the widest human context possible, tries to encompass the constructive implications of health in everyday discourse and highlights the interdependence and indivisibility of human rights (which reinforces the argument that health as a human right is increasingly being recognized on a global scale). It is argued that it is not compulsory to have a definitive meaning of the word ‘health’ to understand the context of the right to health. Preoccupation with technicalities of a word may deter efforts to recognize the wider picture, which is essentially the human right to health and the practical application of such a right. Chapter Two refocused

attention on clarifying the paradigm of the right to health by examining the principle of ‘progressive realization’, the duties and responsibilities of States Parties under international human rights law in respecting, protecting and fulfilling the right and the monitoring instrument in ensuring the right. While taking into considerations that not all countries have the necessary resources to immediately implement the right to health, the principle of ‘progressive realization’ is not an escape clause to avoid responsibilities. Accordingly, States Parties must still take positive and relevant steps towards the realization of the right.

This thesis reveal the main underlying theme this study is concerned about – the economic, social and political arrangements that uphold the circumstances for health security. These not only include non-discriminatory access to health care and services, and access to essential medicines, but also the provision of basic shelter, adequate food, sanitation and potable water as well as environmental health. Section 6 of Chapter One gives a comprehensive account on the contents of the human right to health. It refers to the relevant international documents and applicable instruments which essentially conclude that the right to health is an inclusive right, extending not only to the magnitude of primary health care, but also the underlying determinants of health.

The court cases of the developing world, discussed in Chapters Two and Four, re-emphasize these points by drawing attention to the role played by the right to health in court deliberations (in areas pertinent to access to medicines, access to health care

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facilities, the environment as well in relation to the right to health). Ultimately, achieving the justiciability of the right to health will depend on the willingness of the courts to recognize and apply the right and to consider public health and human rights norms in their deliberations. A noticeable trend is progressing towards this recognition and it is arguable that court cases can at times clarify judicially the human right to health and to ensure the progressive realization of this right.

The right to Health - Developments and Progress under Globalization

“Our children have dramatically different life chances depending on where they were born. In Japan or Sweden they can expect to live more than 80 years; in Brazil, 72 years; India, 63 years; and in one of several African countries, fewer than 50 years. And within countries, the differences in life chances are dramatic and are seen worldwide. The poorest of the poor have high levels of illness and premature mortality. But poor health is not confined to those worst off. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.”

The above paragraph quoted from the Commission on Social Determinants of Health latest report effectively transcribed how poverty, equity and human rights are strongly linked, conceptually and operationally, with health and each other. Whether we are rich or poor, we are confronted with the health challenges connected with globalization.

Chapter Three and parts of Chapter Four demonstrated how the varying circumstance of

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the features of globalization have raised significant challenges for public health (including privatization and reduction of public services) and the influence of market forces which also saw the augmentation of the power of transnational corporations and international private institutions in influencing policy making in many parts of the world, especially in the developing countries. By redefining economic, social and cultural rights particularly the right to health as mere aspirations, the current global order tries to establish a set of values that legitimated particular kinds of social behaviour, and by which some of the most influential players associated with globalization seek to free themselves of costs and duties seen as too onerous and as an unnecessary barrier to their financial interests. The picture is further complicated by the interplay of various health determinants such as economic, institutional, environmental and social-cultural factors at the same time. Thus, one aim of this study is to draw the attention of the reader to the global determinants of health which are known to be among the major causes of poor health and inequality, and how these can affect the development of the right to health.

By analyzing the human right to health in light of globalization, the thesis identified a connection with reality that is at times lacking in human rights dialogue. The temptation to segment the different factors and determinants of health into specific pockets or to analyze the right to health only from a very legalistic and theoretical perspective should be resisted. A health and human rights discourse that is so divorced from current reality of the world is at risk of failing to reflect the dynamic quality of contemporary human rights doctrine.

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Whilst globalization also brings benefits in the advancement of science and technology to improve human health, the shift towards more powerful enterprises and countries playing the roles of dominant and international actors in global governance can also mean that national governments’ sovereignty in regulating services, policies, medicines or even economic activities is greatly affected and reduced. Chapters Three and Four were devoted to analyzing the challenges which surfaced in implementing the right to health and it was shown that the dynamics of globalization dramatically affect the health of the people (be it directly or indirectly) and hamper the progress to achieve ‘Health for All’ and the development of the human right to health in the spirit of social justice.

As mentioned earlier, we are making progress towards a universal recognition of the human right to health. Besides, the struggle for economic, social and cultural rights has been outlined numerous times, from the enshrinement of the rights in international and regional treaties, documents and norms, the gradual growing acknowledgement by the courts of the significance of the right to health in judicial deliberations, to the increasing awareness of the international community about health and social injustice inflicted on the people - especially those in the developing world.

From a legal point of view, it is commendable how far the field of health and the human rights movement has come today, but there is still a long struggle ahead in continuing the efforts of implementing a universal human right to health. The chapters on globalization and access to essential medicines serve to remind us that the global health challenges and threats are real and they can seriously imperil the realization of all human rights, not just the right to health. Putting health in the human rights framework means that leaders in the health and human rights movement have a vital role across all branches of society to
ensure that policies and actions should aim for the improvement of global health. Farmer mentioned how the notion of human rights may at times be brandished as an “all-purpose and universal” tonic, yet we should not forget the fact that it was developed to protect the weak and vulnerable. Many would agree that health is not a commodity. The right to health is fundamental; without it other human rights have less meaning and significance. In linking human rights discourse with public health, and preserving those values in international human rights instruments, it is arguable that everyone can be the proper beneficiaries of international human rights law, not just the poor and the disempowered. If this thesis helps advance the general discourse surrounding the meaning and content of this basic human right, it will have served its author’s original endeavour.

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