

Health as a Human Right

The wrong prescription

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About CEPOS

CEPOS is an independent Danish thinktank promoting a society based on freedom, responsibility, private initiative and limited government.

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Executive summary

Despite life-expectancies rising all over the world thanks to growing prosperity and technological innovation, millions of people still suffer from an intolerable burden of preventable and easily treatable disease. Many health advocates including the World Health Organization, governments and development NGOs argue that a human rights approach to health, which would make governments legally bound to provide healthcare, is the answer to this problem.

When the right to the “highest attainable physical and mental health” was first included in international human rights law, it was well understood by its proponents that this right differs substantially from traditional civil and political rights such as the right to freedom of expression and the right to property.

The latter rights are first and foremost a bulwark against intrusive and arbitrary government action and primarily oblige the state to refrain from such acts. The right to health, on the other hand, requires positive government action and is dependent on available and finite resources. Therefore the right to health was purposely drafted as a political aspiration rather than an individually enforceable right.

This understanding has since been abandoned by the UN and activist legal scholars, who have transformed the right to health via revisionist interpretations of the UN’s Covenant on Economic, Social and Cultural Rights. The result of the activist interpretation has been an unprecedented expansion of the scope of the right to health beyond all reasonable legal basis in international law, effectively creating an individual enforceable right from what was intentionally drafted as a political aspiration.

Furthermore, the revisionist interpretation of the right to health betrays an ideological bias which favours state

funded public health care models over solutions based on patient choice and private health provision. The UN Committee on Economic, Social and Cultural Rights thus often criticises countries which make use of private health provision for undermining the right to health, despite the fact that a number of such countries provide better care than countries with publicly financed health care.

By placing the legal obligation to provide healthcare on governments, the ideologically driven expansion of the right to health risks undermining the rule of law, stifling political pluralism, reducing individual and economic freedom and options for effective policymaking. Research shows that the widespread official promulgation of the right to the highest attainable health has not made any difference to health outcomes anywhere in the world. In some cases it has worsened inequalities and imposed an intolerable burden on local judicial systems. It is also worth noting that countries that have high quality health provision tend to be market economies with a high level of economic freedom.

The right to health is highly problematic when construed as an enforceable right, with the state legally bound to enforce it in a particular and ideologically skewed manner. It would be better interpreted as a human aspiration whose implementation should be left to the democratic process and be decided upon the basis of the political convictions of the electorate. Elected politicians would then be free to implement (or reject) whichever kind of health system is deemed most appropriate by the electorate, without being at risk of breaching human rights – be it predominantly private or state managed.

Nevertheless, competitive markets have already shown

themselves to be fundamental to fulfilling other human aspirations.

If the development community is serious about human rights and improving health, they would switch their focus away from the “right” to health and toward the fundamental rights to personal and economic freedom currently denied to hundreds of millions of people in poorer parts of the world: the right to free speech and the right to own and exchange property.

Health as a Human Right

Introduction

Thanks to huge increases in material prosperity and medical science over the last two centuries, people now live longer, healthier lives than at any other point in human history. Average life expectancies have shot up in almost all countries. However, in some developing nations, there are still significant numbers of people who suffer from preventable disease and rudimentary healthcare – for instance, around 3.8 million children die every year due to preventable or curable diseases such as pneumonia or diarrhoea.

For many, the fact that health varies so wildly across the world in spite of these increases in wealth and science is seen as a grave injustice. This inequality has led many in the development community to demand the provision of healthcare as a human right, with governments legally bound to fulfil this right. This clarion call has been heeded not only by the UN, but government foreign aid agencies and development NGOs around the world.

However, the promotion of the right to health as an enforceable right rather than a policy goal by activist legal scholars and the development community marks a major departure from traditional conceptions of human or ‘natural’ rights. These are best understood as the right of individuals to self determination, and act as a bulwark against government interference. They include the rights to peaceful enjoyment of property and to freedom of expression.

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The widespread official adoption of the right to health and other economic, social and cultural rights represents a major shift from these so-called “negative” rights heralded by the indivisibility approach adopted by the World Conference on Human Rights in 1993. Instead of

simply requiring governments to refrain from actions which might interfere with the pursuit of good health, the activist interpretation of the right to health places specific and wide ranging obligations upon governments to ensure good health

is enjoyed by all citizens. Such “positive” rights have traditionally been understood as political aspirations and policy goals rather than enforceable individual rights. The result of the activist interpretation has been an unprecedented expansion of the scope of the right to health beyond all reasonable legal basis in international law, effectively creating an individual enforceable right from what was intentionally drafted as a political aspiration.

It is not clear that widespread official promulgation of the right to the highest attainable health has made any difference to health outcomes anywhere in the world.

On the contrary, its ideologically driven expansion risks undermining the rule of law, stifling political pluralism, reducing individual and economic freedom and options for effective policymaking.

This paper unfolds as follows. The first section details the right to health in international human rights law, and explores its original conception as an aspiration to be pursued by governments. The second section explores how the right to health was

expanded into a positive and individual right by certain activist scholars and judicial bodies, and examines how this new interpretation results in the unequivocally ideological view that governments should be obliged to collectively fund and provide state healthcare.

The final section examines whether or not the right to health actually improves healthcare, and suggests some other human rights which may be equally if not more relevant to better health.

It is important to note that neither international human rights law nor most national constitutions include an unqualified right to health understood as a right to be healthy. The wide spread use of the term “the right to health” is therefore often misleading suggesting a broad and open-ended right, which has little support in the wording of relevant international human rights law instruments. Despite this normative confusion this paper will generally refer to the term the right to health for reasons of brevity.

The right to health in international human rights law

The right to health found its genesis in the move to codify human rights following the end of the Second World War. Article 25 of the Universal Declaration of Human Rights (UDHR), adopted in 1948, states 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 service.

Article 12 of the International Covenant on Economic, Social and Cultural Rights (the Covenant), adopted in 1966 includes, inter alia, “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”. Article 12 of the Covenant contains obligations on signatory States, such as to take steps to reduce infant mortality and to improve industrial and

environmental hygiene.¹ Since the adoption of the Covenant, international and regional human rights instruments that include the right to health have

proliferated,² and 56 state parties to the Covenant have some form of recognition of the right to health in their national constitutions.³

This official recognition of positive rights such as health has not been

the exclusive domain of the legal community. It has also become practically orthodox within the international development community, led by the UN which has decreed that all its development activities “should further the realization of human rights as laid down in the Universal Declaration of Human Rights and other international human rights instruments”.⁴

Accordingly the UN’s specialised health agencies such as UNICEF, WHO and UNAIDS have adopted a human rights-based approach to their respective areas of work, which often involves health. In 2002 the UN established a Special Rapporteur on the right to health, who serves as an independent expert drafting reports and recommendations to UN organs and member states as well as conducting country visits.⁵

Against this backdrop, the rights-based approach to development and health has become mainstream amongst leading NGOs such as Oxfam and Save the Children, both of whom use the right to health as a key part of their advocacy.⁶

Perhaps unsurprisingly given the influence of the UN and civil society on thinking related to development, the human rights-based approach is now reflected in the official development policies of many major donor countries including Denmark, Canada, the United Kingdom, Australia, Norway and Sweden.⁷ In the UK, human rights have been explicitly placed at the centre of all the activities of its development agency, DfID.⁸

With various health-related rights now included in numerous

international human rights treaties ratified by a majority of the world’s states, and at the basis of much

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development policy, a rights-based approach to health would appear to be uncontroversial. But when it comes to enforcing and implementing the right to health, it not only becomes practically and legally difficult. The right to health may actually undermine the efforts to improve health for all.

The original understanding of the right to health

Compared to human rights treaties on civil and political rights the right to health – and most other economic, social and cultural rights – is drafted in relatively vague and imprecise language. The wording of the right to health in article 12 of the Covenant originates from a proposal submitted by a former Director General of the WHO,⁹ who emphasised that the obligations imposed by the right to health should vary for each country,

with due allowance for their resources, their traditions and for local conditions. Some Governments with immense financial resources can concentrate on highly specialized problems and provide measures which only benefit a very small number of people, while others have still to create a medical profession and health services before they can contemplate action of any kind¹⁰

The deliberate vagueness of the normative content of the right to health should be seen in conjunction with article 2(1) of the Covenant, which states that the parties must

take steps...to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures

The wording clearly suggests that with certain exception – such as a requirement of non-discrimination – the rights in the Covenant are policy goals or aspirations rather than enforceable individual rights. This is in stark contrast to the Covenant on Civil and Political rights, written at the same time, which typically mentions signatories' immediate obligation to “ensure” the rights therein. This understanding is confirmed by the drafting history of the UDHR and the Covenant. Even many of the individuals and states that supported the concept of economic, social and cultural rights expressly

acknowledged that these rights were of a different kind of nature than the classic civil and political rights and that therefore individual enforcement would be extremely difficult and therefore undesirable.¹¹

When the UDHR was being considered, one of its “founding fathers” René Cassin continuously emphasized the different nature of economic, social and cultural rights, even while supporting the inclusion and importance of such rights in the UDHR.¹² These sentiments were also shared by Eleanor Roosevelt and Charles Malik and even the socialist John Humphrey acknowledged individual enforcement of economic and social rights was unrealistic.¹³ Roosevelt explicitly stated that “the basic differences between civil and political rights and economic, social, and cultural rights warrant this division into two covenants”.¹⁴

Even today governments are divided about the nature of the Covenant, with a significant number of states holding that the rights therein are non-justiciable. The United Kingdom for instance insists that the Covenant constitutes “mere principles and values and that most of the rights contained in the Covenant are not justiciable”¹⁵ whereas Poland is sceptical of judicial enforcement of the Covenant because it invites “rulings based on the political preferences of the members of the Committee on Economic, Social and Cultural Rights rather than on strict law”.¹⁶ This scepticism is ironically shared by some of the very same countries that have included the right to health in their development policies such as Denmark, Canada, Australia and Sweden.¹⁷

The development of the right to health

The Committee on Economic, Social and Cultural Rights

The original understanding of economic and social rights, such as the right to health, as being aspirational and policy oriented rather than strictly legal in nature has undergone an almost revolutionary change. The human rights movement including UN experts have “developed” the understanding and nature of these rights so as to include obligations wholly absent from the wording and drafting history of the Covenant. The

main body responsible for this development has been the Committee on Economic, Social and Cultural Rights (the Committee) which is the treaty body responsible for overseeing the Covenant. According to an article written by two international lawyers from the US State Department, Michael J. Dennis and David P. Stewart, the Committee's interpretation of the Covenant is "revisionist" and amounts to a "unilateral alteration in the substantive content of the Covenant or in the obligations there under"¹⁸ – in effect changing the essence of a ratified treaty without the consent of the signatories. This legally and democratically dubious development has been enthusiastically embraced by the human rights and development community, including the World Health Organization. As such the Committee's interpretation has been an important driver in development policy related to health.

The revisionist approach of the Committee is all the more worrying due to the fact that its legitimacy can be questioned. While all members of the Committee are elected in their personal capacity and thus act as independent experts several Committee members hold high-ranking government jobs including Committee members from authoritarian states such as Belarus. It is also worth noting that of the non-lawyers on the Committee few have formal training in economics. Economic understanding, which is crucial to the areas covered by the Covenant, is therefore very limited among the Committee members, some of which are openly hostile to conventional economic thinking.¹⁹ The lack of economic understanding prompted a former member of the Committee to resign stating that the Committee did not take cognizance of reality and therefore could not function properly.²⁰

Moreover, membership of the Committee is only a part-time job and the Committee normally only convenes twice a year for sessions of three weeks' duration – each

covering the human rights situation in 5–8 countries – with a one-week pre-session working group. The membership and working methods of the Committee raises serious questions about its ability to carry out a thorough and sufficiently qualified analysis of the complex areas covered by the Covenant, which includes not only health but also issues such as housing, social security and employment. The lack of appropriate time and expertise has resulted in the Committee putting a lot of emphasis on so-called "shadow-reports" from NGOs.²¹ While input from NGOs may be valuable many NGOs pursue special interests and political agendas, which agendas may therefore assert a disproportionate influence on the Committee. The role of the Committee will become increasingly important with the recent adoption of an optional protocol to the Covenant, which will allow individual complaints, including ones alleging a violation of the right to health. Such complaints will be decided by the Committee once the optional protocol enters into force.

The General Comment

The Committee has drafted a number of general comments on the interpretation of the rights in the Covenant including one on the right to the highest attainable health (the General Comment).²² The Committee also issues concluding observations and comments on state reports, which states party to the Covenant are obliged to submit every five years. Despite its initial moderation, the WHO has been a firm supporter of the Committee's efforts, involving itself in the drafting of the General Comment²³ and adopting a human rights approach to health.²⁴

The General Comment sets out extremely broad and wide ranging obligations for signatory States, and has clearly been influenced by health advocates, stating that citizens should not only have a right to 'timely and appropriate healthcare' but also to socio-economic determinants of health such as housing, water and so on.²⁵ This has

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prompted even fervent supporters of the Committee and the Covenant to question the legal nature of some of the many directives included in the General Comment.²⁶

According to the Committee the right to health includes four essential elements (a) availability, (b) accessibility, (c) acceptability and (d) quality, which must all be fulfilled. The Committee also claims the right to health includes “core obligations” – minimum requirements which must be satisfied immediately without regard to resource constraints. It should be noted that the minimum core-obligation has no basis in the wording or the drafting history of the Covenant and is largely inspired by the efforts of academics.²⁷ The minimum core obligation under the right to health imposes a number of duties on governments, including ensuring access to health facilities and goods and services; food; shelter; sanitation; essential medicines as well as the duty to ensure equitable distribution of all these things. It is interesting to note that the South African Constitutional Court stated that “It is impossible to give everyone access even to a ‘core’ service immediately” explicitly rejecting the Committee’s approach in a case based on the right to health, which right is included in the South African constitution.²⁸

The Committee also insists that the right to health (like all Covenant rights) gives rise to tripartite obligations to “respect, protect and fulfill”. This terminology is also derived from the work of academics rather than the wording or drafting history of the Covenant.²⁹ The duty to respect is mainly negative in character, in that it obliges the state from directly interfering with the right to health. Contrastingly, the duty to protect obliges states to ensure that third parties do not interfere with the right to health. Accordingly the state may be liable for the actions of private individuals and corporations in the health care sector, which may give rise to governments interfering with contractual freedom by requiring private health care providers to pay for medical services not included in insurance schemes. The special rapporteur on health has gone even further by stating that pharmaceutical companies may be directly bound by the Covenant despite the fact that the Covenant only binds states and not private companies or individuals.³⁰

The most far reaching obligation is the obligation to fulfil, which requires states to “adopt appropriate

legislative, administrative, budgetary, judicial, promotional and other measures towards the full realisation of the right to health”.³¹ States may thus be held accountable for a wide number of acts and omissions without being able to foresee which acts and omissions will constitute potential violations of the Covenant.

The following excerpt from the General Comment provides a good example:

A State which is unwilling to use the maximum of its available resources for the realization of the right to health is in violation of its obligations under article 12. If resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above.

However, there is no objective way to define “available resources”, nor to determine whether such resources have been used to their “maximum”. Such determination will by definition depend on subjective priorities among competing interests, the balancing of which will depend on political preferences. Such matters remain essentially subjective, despite the Committee’s attempts to make them concrete.

How do you for instance determine whether steps taken by a state are “reasonable” or “adequate” as required by the Committee?³² Moreover, the Committee’s insistence that each Covenant right will be violated if the state does not use the maximum of its available resources to fulfil it shows the circular, self-contradictory and incoherent interpretation of the Committee. By definition no state can use the maximum of its available resources on several Covenant rights at the same time, since these rights compete for the same and limited resources. If a state cuts spending on education, welfare or housing and increases spending on health the Committee’s interpretation could arguably lead to praise for prioritizing health and to a violation for giving insufficient priority to the Covenant rights affected by cuts. Therefore a state will always be open to the charge that it has not spent enough on the right to health or other Covenant rights.

Not only does this dramatic expansion of the right to health conflict with the wording and the original intent of article 12, but it also undermines the rule of law by obscuring foreseeability and legal clarity.

The inherent problems with foreseeability and resource allocation show the fundamental difference between Covenant rights such as the right to health and civil and political rights such as the prohibition against torture and freedom of speech. Regardless of whether a country is rich or poor, closing down an opposition newspaper and torturing its journalists is a clear violation of these rights. Upholding such rights does not depend on resources nor on any abstract policies being put in place by governments other than observing the rule of law.

However, the revisionist interpretation of the right to health is obviously appealing to left-leaning NGOs and their allies in the development community, who can buttress their ideological desire for more collective, state action and redistribution with human rights language, claiming that a particular government has not used “the maximum” of its available resources on health. In this way, the development community absurdly insists that economic, social and cultural rights are “indivisible” from civil and political rights despite the obvious differences. Not only is this approach impossible to reconcile with reality. Focusing on “the right to health” and other economic, social and cultural rights also serves as a convenient way for authoritarian states to deflect attention away from violations of the most basic civil and political rights with the result that international human rights efforts at the UN increasingly focuses on perceived unequal distribution of global resources rather than on securing respect for individual freedom and the rule of law.

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The ideological agenda of the right to health

It is increasingly clear that the agenda of those advocating the right to health is highly political. This is notably the case in their opposition to healthcare systems that rely on competition and patient choice.

While the Committee recognises that health care systems that rely on the private sector may comply with the Covenant, there is little doubt that the Committee is suspicious and sometimes downright hostile towards private health care. Its

concluding observations have for instance heavily criticised the predominance of private healthcare within the Republic of Korea³³ and Switzerland,³⁴ despite these countries’ relatively good performance in healthcare.

The Committee has never substantiated its claim that private health care systems are harmful to marginalised groups or that public health systems are better at serving the health of the population in general. The potential benefits of competition in the health sector, of increased choice for patients, or of the potential of private health care to help alleviate waiting lines in the public health sector are similarly ignored.

The Canadian *Chaoulli* judgment

The Canadian Supreme Court’s judgement in the *Chaoulli* case exemplifies the Committee’s antipathy to

patient choice in healthcare. In Canada, private health insurance had long been banned in many provinces on the basis that it would undermine the country’s public, universal healthcare system. In 2005 the Canadian Supreme Court ruled that Quebec’s ban on private health insurance interfered with the right

to life and physical integrity. This judgement was met with suspicion by the Committee and a great deal of hostility from human rights activists and scholars, many of whom believed that it undermined the right to health.³⁵ However, it could reasonably be posited that the long waiting lists that characterise Canada’s public

health also threaten the lives of patients awaiting treatment.³⁶ This kind of rationing falls squarely within the Committee’s own definition of the right to health and could be construed as a violation of both the obligation to “respect” and “fulfill”. Yet the Committee not only omits any reference to these serious deficiencies in the Canadian health care system.

It also implies that the freedom to voluntarily enter into contracts with private health care providers and thereby potentially save one’s own life goes against the right to health. This is clearly absurd, yet even when a publicly financed health system shows deficiencies, the Committee will favour it over alternatives.

The Committee’s insistence on the superiority of public health care systems is ideological. Despite there being a plethora of evidence documenting the failures of the Canadian healthcare system relative to those of peer countries that make greater use of the private sector in health³⁷, none of this was mentioned by the Committee.³⁸

The Committee’s attitude towards health systems based on choice and competition mirrors that of most human rights academics. This is no coincidence since academics have been highly influential in “developing” the Committee’s interpretation of the right to health and the Covenant in general. Many academics have argued that realising the right to health is dependent on pursuing a number of clearly social democratic policies such as redistributory taxation, and a rejection of ‘neo-liberal’ economic policies – without providing any supporting data or analysis.³⁹

The anti-market assumptions of the Committee and the development community have been described thus:

many of those who promote the cause of economic and social rights do so as a camouflage for arguing in favour of a particular sort of economic and social organisation. ... The rhetoric about economic and social rights is characterised by an intellectual laziness exemplified by the unargued assumption that realisation of economic

and social rights requires systematic redistribution of wealth. Most of this rhetoric is provided by writers who clearly have little understanding of or sympathy for economics and who, in particular, do not understand the role of the market in allocating resources and enabling individuals to make their own choices.⁴⁰

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The ever increasing and ideologically fuelled normative content of the right to health has been an important ally of the development community’s anti-market bias. Activists can use the supposed legal obligations of the right to health to demand that governments

implement “human rights consistent” policies – in practice, policies that favour state provision of health services.⁴¹ Oxfam, for instance, has criticised the World Bank’s promotion of private health insurance and service delivery on the basis that it does not respect, protect and fulfil the right to health.⁴² Médecins Sans Frontières has repeatedly stated that access to medicines is a human rights issue, arguing that governments should ensure the equitable distribution of drugs by abrogating the patents of right-holders.⁴³ Oxfam has similarly argued that medical research and development priorities should be determined by governments rather than the private sector, and that privately-held intellectual property rights should be disregarded.⁴⁴

However, these NGOs’ interpretation of the right to health is influenced by ideology rather than sound legal reasoning or research into effective public policy. By presenting their collectivist policy proposals as human rights obligations and market-based alternatives as human rights violations, such NGOs automatically place opponents on the defensive: after all, few governments or agencies wish to be perceived as opposed to something as fundamental as human rights.

The more the right to health becomes entrenched at the domestic and international level, the greater the risk that alternative policies based on competition and individual choice will be stifled – particularly if enforced by courts. This has grave consequences for political

pluralism, and effective policymaking. Democratic governments should reflect the desires of the citizens who elected them. These desires may reasonably and legitimately differ from the revisionist interpretation of the right to health.

Discussion: Which rights need to be enforced to improve health outcomes?

While proponents of the right to health frequently stress its legal and moral imperative, they rarely discuss whether or not the State is well-placed to actually deliver high quality, universal healthcare. To ignore such practical considerations seems to be a major gap in the discourse, especially when arguing that state-managed care should be preferred (and legally required) over alternative methods of delivering healthcare.

The human rights literature often simply assumes that once an abstract “right to health” is enshrined into law, the state will be capable of planning, implementing, managing and financing equitable, high-quality healthcare. The reality is very different, largely because state bureaucracies are not well-placed to anticipate and cater for the vastly differing and constantly changing health demands and needs of a population.

If the state is to be responsible for delivering healthcare, it requires a group of individuals working for the health ministry to have a detailed and thorough knowledge of the healthcare requirements of all their citizens at any given moment in time. For resources to be distributed effectively, bureaucratic planners will need to know exactly what diseases are most common in each locality, how many physicians, diagnostic tools and drugs are required, and so on. These requirements shift constantly as demand rises and falls depending on changes in the population, most of which are unpredictable. To be effective, planners will need to be in possession of thousands – if not millions – of pieces of constantly changing information.

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In practice this is impossible, and the end result is waiting lists, shortages and other forms of rationing. In Canada’s state-managed healthcare system in 2008 for instance, only 84 per cent of individuals over 12 years old had regular access to a physician.⁴⁵ The inherent failures of planning are also manifest in Britain’s National Health Service, which has longer waiting lists and greater rationing of medical technology than peer OECD health systems that are more decentralised and make greater use of the private sector – such as the Netherlands, France, and Switzerland. For instance,

cancer survival rates in Britain are amongst the lowest in Europe,⁴⁶ in spite of the fact that Britain spends an equal or greater proportion of its GDP on health.

The experience of Canada and Britain contradicts the belief of the development community that the state is by definition the best agent

to realise the right to health. Furthermore, the revisionists’ belief that the right to health should be justiciable is challenged by the experience of developing countries such as Brazil. Brazil’s constitution explicitly recognises the right to health, but many patients who call upon the state to fulfill this obligation are frequently met with shortages and stockouts in state pharmacies. Many of these patients have therefore – quite reasonably – responded by suing the government.⁴⁷ The right to health has therefore led to an explosion of judicial challenges by patients against the government, with more than 1200 cases of judicial review sought in the

Rio Grande do Sul region alone each month. Such claims act as a major burden on the judicial system as well as a heavy fiscal burden on the government.

There are also severe ramifications for equity. Rather than making access to healthcare universal, in Brazil the enforceable right to health has had the perverse consequence of favouring the politically connected or those who can afford the high cost of judicial review. In the word of the researchers, “the right to health generates enormous administrative and fiscal burdens and has the potential to widen inequalities in

healthcare delivery.” Also, as a consequence of the increasing amount of resources devoted to the right to healthcare the state will be forced to undermine the provision of other necessary public services, such as policing and justice.

The reality is that there is little evidence that the rights-based approach has any effect whatsoever in improving health. Many countries – including France, Switzerland and Singapore – do not explicitly recognize an individually enforceable right to health in their national constitutions yet manage to deliver extremely high quality and equitable healthcare.

Neither does the ratification of human rights treaties make any difference to population health, as demonstrated in a recent study published in *the Lancet*.⁴⁸

More importantly, the *Lancet* study also found that established market economies have far better health indicators than African, Asian and former Soviet countries, most of whose economies are far away from the free-market ‘neoliberalism’ denigrated by human rights activists.⁴⁹ The reason why market economies tend to do better than countries in which there is less economic freedom is that they better generate the wealth necessary for financing better health (whether privately through employees being able to afford health insurance or publicly financed through taxation). Even Scandinavian welfare states like Denmark and Sweden that have large public sectors are conscious of the need for economic freedom to finance the generous entitlements enjoyed by their citizens.

According to the International Property Rights Index, Denmark has the second highest protection of private property globally whereas Sweden and Norway are tied at fourth.⁵⁰ Denmark is also ranked 9th when it comes to overall economic freedom.⁵¹

The right to health is highly problematic when construed as an enforceable right, with the state legally bound to enforce it in a particular and ideologically skewed manner. It would be better interpreted as a human aspiration whose implementation should be left to the democratic process and be decided upon the basis

of the political convictions of the electorate. Elected politicians would then be free to implement (or reject) whichever kind of health system is deemed most appropriate by the electorate, without being at risk of breaching human rights – be it predominantly private or state managed.

Nevertheless, competitive markets have already shown themselves to be fundamental to fulfilling other human aspirations. Food is necessary for survival, but governments rarely own supermarkets or manage food supply chains and hunger is almost unheard of in

market economies. Thanks to markets and their attendant technological innovation, food is cheaper and more abundant than ever before. The same is true of clothing. Markets have already contributed to the realisation of the right to health by encouraging technological and pharmaceutical

innovation, and distributing that knowledge all over the world via international trade.⁵²

If the development community is serious about human rights and improving health, they would switch their focus away from the “right” to health and toward the fundamental rights currently denied to hundreds of millions of people in poorer parts of the world: the right to free speech and the right to own and exchange property.

These are the rights that will let people lift themselves out of poverty, giving them the resources to afford clean drinking water, adequate shelter, good nutrition and the decent healthcare systems necessary to achieve good health. These are the rights that matter most and that are therefore truly worthy of the term “Human Rights”.

“It would be better interpreted as a human aspiration whose implementation should be left to the democratic process and be decided upon the basis of the political convictions of the electorate.”

Notes

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
 - b) The improvement of all aspects of environmental and industrial hygiene;
 - c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.
2. See, inter alia, article 16 in the African Charter on Human and Peoples' Rights, article 10 in the additional protocol to the American Convention on Human Rights, article 24 of the United Nations Convention of the Rights of the Child, article 35 of the EU Charter on Fundamental Rights, Article 11 of the European Social Charter, and Article 11 of the Revised European Charter.
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10. Ibid.
11. Michael J. Dennis and David P. Stewart "Justiciability of economic, social and cultural rights: Should there be an international complaints mechanism to adjudicate the rights to food, water, housing and health?" in *American Journal of International Law*, Vol. 98, No. 3 (Jul., 2004) pp. 462–515, pp. 476–489. See also Whelan, Daniel, *Indivisible Human Rights: A History*. University of Pennsylvania Press (forthcoming, 2010).
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15. Concluding Observations of the Committee on Economic, Social and Cultural Rights United Kingdom of Great Britain and Northern Ireland, the Crown Dependencies and the Overseas Dependent Territories E/C.12/GBR/CO/5 22 May 2009
16. See UN Doc. A/C.3/63/SR.40 at para. 40.
17. See A/HRC/8/7 of 23 May 2008
18. Dennis and Stewart op.cit. note 11 p. 494
19. For criticism of the Committee's lack of macroeconomic understanding see Mary Dowell Jones, 2004, *Contextualising The International Covenant On Economic, Social And Cultural Rights: Assessing The Economic Deficit*, Martinus Nijhoff Publishers, p. 2. The Committee's former chairman has stated that "Descriptions of macro or even microeconomic policies...are in fact of no intrinsic value". Ibid p. 5.
20. UN Doc. E/C.12/1994/SR.24 at para 1–4.
21. M. Langford and Jeff A. King, the Committee on Economic, Social and Cultural Rights in M. Langford (ed.), 2008, *Social Rights Jurisprudence Emerging Trends in International Law*, Cambridge University Press, p. 481.
22. The right to the highest attainable standard of health: 11/08/2000. E/C.12/2000/4.
23. Gunilla Backman et al. 2008. "Health Systems and the right to health: an assessment of 194 countries", *Lancet* **372**: 2048.
24. The WHO has dedicated a website to the issue of health and human rights. See <http://www.who.int/hhr/en/>. See also http://www.who.int/hhr/HHRETH_activities.pdf for an overview of the WHO's work on human rights and health.
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 34. Conclusions and recommendations of the Committee on Economic, Social and Cultural Rights, Switzerland, U.N. Doc. E/C.12/1/Add.30 (1998) para. 24 and 36.
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Health as a Human Right

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Should healthcare be a human right?

The idea that governments should be legally obliged to provide healthcare for its citizens is now an apparently uncontroversial idea. The “right to health” forms the basis of policy for the UN, many international NGOs and national development agencies, and exists in the constitutions of many countries.

The political and legal ascendance of the right to health is unwarranted and counterproductive, according to International Human Rights academic Jacob Mchangama. Turning healthcare into an individual enforceable right creates all kinds

of legal complexities, undermines the rule of law and stifles political pluralism. Neither is there any evidence that “the right to health” has actually improved healthcare anywhere in the world – in some cases it has undermined it.

In reality, the rights which are really fundamental to improved healthcare are those which underpin prosperity and economic development – such as the right to own and exchange property. Such rights are denied to millions, yet are vital for creating the prosperity needed to pay for good healthcare.