

A b s t r a c t

This paper discusses the concept of the right to health in international human rights law. The phrase "right to health" is not a familiar one, although the Constitution of the World Health Organization and a number of international human rights treaties recognize the right to the "highest attainable standard" of health. The use of "right to health" terminology is discussed, and the language of international declarations and treaties referring to a right to health is cited. The author contends that approaching health issues through a rights perspective adds an important dimension to consideration of health status. The shorthand, "right to health", emphasizes the link of health status to issues of dignity, non-discrimination, justice, and participation. The paper delineates the efforts of United Nations organs as well as human rights scholars and activists to develop the scope and obligations of the right to health. The relation of economic resources to its implementation is discussed. A section is devoted to the issue of the right to health in relation to women.

Este ensayo discute el uso incrementado del concepto del derecho a la salud en la literatura legal, médica y filosófica y sugiere la importancia que debería darse a este derecho. El enfoque de este ensayo es sobre los aspectos internacionales del estado y los servicios de salud. Se sustenta que enfocando los aspectos de salud a través de una perspectiva de los derechos se incorpora una dimensión importante y práctica a la consideración del estado de salud. La frase "el derecho a la salud" no es un término familiar, aunque la Constitución de la Organización Mundial de la Salud y numerosos tratados internacionales sobre los derechos humanos reconozcan el derecho a "el goce del grado máximo de salud que se pueda lograr. La expresión taquigráfica "el derecho a la salud" enfatiza la unión del estado de la salud a los aspectos de dignidad, igualdad, justicia y participación. Puesto que la mayoría de los estados han ratificado tratados internacionales reconociendo el derecho a la salud, en este artículo la atención se centra en los esfuerzos de los organismos de las Naciones Unidas, académicos y activistas de los derechos humanos para definir el derecho a la salud. La última sección del artículo examina las obligaciones específicas de los estados que pueden ser deducidas a partir de la aceptación del concepto del derecho a la salud.

Cet article examine le concept du droit à la santé sous l'angle du droit international des droits de l'homme. Cette expression de "droit à la santé" n'est pas commune, quoique la constitution de l'Organisation Mondiale de la Santé et un bon nombre de traités internationaux des droits de l'homme reconnaissent le droit au "meilleur état de santé qu'il est capable d'atteindre". L'utilisation de la terminologie "droit à la santé" est discutée et le langage des déclarations internationales et des traités relatifs au droit à la santé est cité. Il est soutenu qu'une importante dimension de la considération du statut de la santé est prise en compte et ajoutée lorsque les questions de la santé sont abordées sous l'angle des droits de l'homme. Le terme "droit à la santé" souligne le lien entre le statut de la santé et les questions de dignité, de non-discrimination, de justice et de participation. L'article présente les efforts des organismes des Nations Unies, des chercheurs et des activistes des droits de l'homme en vue de développer la portée et les obligations du droit à la santé. Le rôle des ressources économiques dans la mise en place du droit est discuté et une section est consacrée au problème du droit à la santé en relation avec les femmes.

THE RIGHT TO HEALTH

IN INTERNATIONAL HUMAN RIGHTS LAW

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In this essay, health issues are examined through the lens of a “right to health”—a phrase that elicits a number of questions:

- What does the phrase mean?
- What are the implications of referring to a “right” in the context of health?
- What is the origin or source of such a right? Does it have any basis as a legal right?
- Does the term imply a right only to health care or are other rights implied also?
- How can a right to health be guaranteed, since no person or state authority can guarantee good health to anyone?

Of course, these questions touch on ethical and philosophical issues. But in this essay the right to health is considered only from the perspective of international law, and not from that of morality or philosophy.

The “enjoyment of the highest attainable standard of health” has been recognized as a “fundamental right” by the international community since the adoption of the Constitution of the World Health Organization (WHO) in 1946.¹ Numerous international human rights treaties—many of which have been

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widely ratified—also recognize the right. While all of these declarations and treaties contain provisions on rights and health, the language of each varies widely; it has become customary to refer to these provisions collectively as constituting the “right to health.”

The first section of this essay explains that the phrase “right to health” is used in the international human rights context to refer to (1) the more lengthy and detailed provisions relating to health in the WHO Constitution and in legally binding human rights treaties and (2) to emphasize the social and ethical aspects of health care and health status. This shorthand expression has its critics, but the phrase has now attained generalized usage in human rights literature. The meaning of “right to health” is discussed in the first section and contrasted with the terms “right to health care” and “right to health protection.”

The second section of the essay considers the source of the right to health in human rights law. In particular, the manner in which international human rights law has evolved since World War II to include economic and social rights is discussed. Provisions on the right to health in the main human rights instruments are cited. Brief reference is made to some provisions of national constitutions relating to the right to health and health protection.

Although enunciated in international instruments, the scope and meaning of the right to health as a *human right* is only gradually being clarified. With the notable exceptions of an excellent study by the Pan American Health Organization (PAHO)² and a workshop at The Hague Academy of International Law,³ there have been few serious efforts by international organizations or scholars to consider the scope of the right to health. Nevertheless, it is not unusual for the full implications of a right enshrined in a bill of rights or a human rights treaty to be perceived only gradually: rights proclaimed in national constitutions and in international legal instruments are expressed in succinct language whose meaning is rarely self-evident.

Moreover, the content and implications of a right develop over time through judicial and administrative interpretation in and application to concrete cases, as well as through scholarly analyses.

In interpreting civil and political rights (such as freedom

of expression or freedom of association), international organs applying human rights law have been able to benefit from the experience of national legal systems. However, national legal systems do not have a large body of experience in interpreting and implementing the economic and social rights recognized in international treaties. In this regard, the right to health shares the same fate as other economic and social rights, such as the right to food and the right to housing—also recognized in international treaties—whose meaning is only gradually being clarified.

International human rights treaties commonly create monitoring committees whose role is to interpret and apply the treaties' provisions and to engage in a dialogue with the ratifying states as to their application. Most of these committees have had a short history compared to that of national judicial systems. Economic and social rights, including the right to health, are only beginning to be clarified by monitoring committees.

The third section of the paper considers implications of human rights discourse in relation to health issues. The concept of a right to health implies that fundamental principles of human rights—dignity, non-discrimination, participation, and justice—are relevant to issues of health care and health status.

The meaning to be ascribed to the right to health, as well as the obligations of states to ensure that right, is examined in the fourth section of the paper. This involves reference to provisions of international instruments, WHO's work in this area, efforts of monitoring committees, scholarly literature, and public health approaches. Unfortunately, space limitations restrict the discussion to a few basic issues concerning the scope of the right.

In the fifth section, two important issues related to implementation of the right to health have been selected for particular consideration: (1) relation of economic resources to implementation of the right to health, and (2) non-discrimination as it relates to women's rights and health.

The essay's conclusion suggests some issues, not previously discussed at length, that should be pursued in considering the scope of the right to health. Emphasized is the need for collaboration among human rights scholars and practitioners, WHO, UNICEF, and public health and development experts, in order to further elucidate the central content of the right to health as a human right.

I. Terminology: The Right To Health—A Shorthand Expression

On first hearing it, the phrase “right to health” strikes many as strange. It is not a common expression in national legal systems and it is not a term familiar to many in the field of medicine and public health. Notwithstanding, there are a number of references to the right to health (and health care) in philosophical literature, and it is becoming a familiar term in the context of international human rights. Superficially, the “right to health” seems to presume that government or international organizations or individuals must guarantee a person’s good health. This interpretation is obviously absurd and the phrase is not given such an interpretation in the context of human rights law.

As mentioned in the introduction, the term “right to health” is currently used in the context of human rights as shorthand, referring to the more detailed language contained in international treaties and to fundamental human rights principles. The precise terminology “right to health,” without further explanation, is not used in most provisions of treaties relating to health. (See Section II for language employed in international treaties.) The following examples, among many possible, evidence extensive use of “right to health”—in the sense outlined above—by international organizations, human rights organs, and legal scholars:

- 1) The Committee on Economic, Social and Cultural Rights, which monitors the application of the Covenant on Economic, Social and Cultural Rights⁴ (hereinafter the “Economic Covenant”), held a “Day of General Discussion on the Right to Health” on 6 December 1993, focused on the meaning to be attributed to Article 12 of that Covenant which provides “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.”⁵
- 2) A 1993 WHO publication entitled *Human Rights in Relation to Women’s Health*⁶ contains a number of references to women’s “right to health,” and considers the meaning of that right by detailed references to the WHO Constitution, the Economic Covenant, the Convention on the Elimination of All Forms of Discrimination against

Women⁷ (hereinafter the “Women’s Convention”), and the Convention on the Rights of the Child⁸ (hereinafter “Children’s Convention”).

- 3) In 1989, the Pan-American Health Organization (PAHO) published a lengthy study on *The Right to Health in the Americas*⁹, edited by two lawyers with extensive experience in health law. In support of the existence of the right to health as a legal right in international law, they cite detailed provisions of the WHO Constitution and international human rights treaties.
- 4) In the same PAHO publication, Judge Thomas Buergenthal wrote an article entitled “International Human Rights Law and Institutions.” He referred on a number of occasions to the right to health as dealt with in various international human rights instruments.¹⁰
- 5) In 1978, the Hague Academy of International Law and the United Nations University organized a multi-disciplinary workshop on *The Right to Health as a Human Right* with participants from the fields of law, medicine, economics and international organizations. It established the phrase “right to health” within the context of international human rights and drew attention to sources of the right.¹¹

In a paper submitted to the workshop entitled “The Right to Health,” Professor Theo C. Van Boven, then Director of the United Nations Division of Human Rights and subsequently Professor of International Law at Limburg University, Netherlands uses the term “right to health” to refer to provisions in the founding documents of international human rights law. Cited were provisions in the Universal Declaration of Human Rights and the Economic Covenant and a number of other declarations.

Van Boven 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 human 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.”¹²

The use of shorthand expressions to express more complete concepts is common in human rights, civil rights, and fundamental rights. Reference may be made in fundamental rights literature to the "right to property"; the acquired meaning is not that everyone has the right to demand some property, but that no one may be arbitrarily deprived of his or her property. The term's meaning has developed through long usage and application in legal systems. This is in keeping with the evolution of the scope of concepts like "due process," "natural justice," "equal protection," and of rights to freedom of expression or freedom of association. At first these terms were not self-evident, but through judicial, legislative and scholarly use in many countries they have acquired a generally recognized meaning.

Use of rights language in connection with health has led to controversy in the United States, despite its acceptance internationally. Furthermore, whereas the concept of a right to health care is more specific and more readily understood than the right to health, the use of this more specific phrase has also been criticized. For example, a recent publication entitled *The Right to Health Care*, edited by two American authors, contains a number of chapters by philosophers and economists, some favoring the concept of a right to health care and some opposing it as rhetorical, lacking in specificity and diversionary from the real problems of medical care.¹³ In that publication, some contributors reject a right to health care on ideological grounds as authorizing "the coercive redistribution of individuals' resources."¹⁴ Those writing in favor of the terminology perceive the use of rights language as emphasizing aspects of equity and fairness in the provision of medical care.¹⁵ Only one contribution in the volume makes even passing reference to international declarations or treaties relating to the right to health and health care.

In its 1983 report, the Commission for the Study of Ethical Problems in Medical and Biomedical and Behavioral Research, appointed by the President of the United States, rejected the concept of a right to health care as an ethical basis for reforms of the United States health care system, although a 1953 Presidential commission had endorsed the expression.¹⁶ The primary reason for the 1983 rejection appeared to be that such a right is not included in the Bill of Rights to the American Constitution. It may also have reflected the anti-social rights orientation of the Reagan

Administration, in power at that time.

Currently, the Science and Human Rights Program of the American Association for the Advancement of Science (AAAS) is completing a project exploring implications of recognizing a right to health care. Through a series of consultations with experts in medicine, law, philosophy, economics and ethics, the project has made a major contribution to understanding the limited right to health care. Many of the proposals emanating from the project explore issues essential as well for recognition of the right to health.¹⁷

Professor Ruth Roemer, writing in PAHO's *Right to Health in the Americas*, entitles her contribution "The Right to Health Care,"¹⁸ endorsing the opinion that the phrase "right to health" conveys an absurdity: the guarantee of perfect health. However, she goes on to give an extensive definition to the right to health care, considering it to encompass "protective environmental services, prevention and health promotion and therapeutic services as well as related actions in sanitation, environmental engineering, housing and social welfare."¹⁹ Such an extensive definition seems contrary to common understanding of the phrase "right to health care," normally taken to mean only the provision of medical services. Her usage illustrates, however, the negative reaction of many to the phrase "right to health"—a reaction that will only lessen as the term's use and implications become more familiar.

The PAHO study's authors also express certain hesitations about the use of the term "right to health":

In summary, the editors recognize that the phrase *a right to health* may be incomplete and conceptually misleading. We suggest that a more correct phraseology would be *a right to health protection*, including two components, *a right to health care* and *a right to healthy conditions*.²⁰

In the end, however, they opt for the term "right to health" in their book's title for "the sake of convenience and to conform to standard usage in human rights texts...."²¹ As pointed out by the editors of the PAHO study and others, the term "right to health" is used for convenience and has become standard in the field of human rights, but it is not the precise language of the legal instruments, which are explored in the following section.

II. International and National Legal Provisions

International Provisions

A number of international treaties and declarations use the language of rights in referring to health issues. Only those paragraphs of articles using rights language are cited in this section. A number of these same articles contain additional paragraphs listing measures to be taken by states parties to ensure the enjoyment of the rights. These are discussed in Section IV, on the scope of the right to health.

Although the 1948 Universal Declaration of Human Rights²² is not a treaty, most of its provisions are now considered by legal scholars as constituting customary international law. Article 25 of the Declaration reads:

Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and the right to security in the event of...sickness, disability..."

The language of the WHO Constitution has inspired the provisions of several treaties:

- *WHO Constitution* (Preamble)

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 conditions.

- *International Covenant on Economic, Social and Cultural Rights*

Article 12(1): The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

- *Convention on the Rights of the Child*

Article 24(1): States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health.

- *African Charter on Human and Peoples' Rights*²³

Article 16: Every individual shall have the right to enjoy the best attainable state of physical and mental health.

The important WHO and UNICEF Declaration of Alma-

Ata adopted at the International Conference on Primary Health Care in 1978, also used similar language:

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

It should be noted that the use of the language “highest attainable standard” in these documents presupposes a reasonable, not an absolute, standard. Also, the language of the WHO Constitution emphasizes an essential element implicit in the shorter phrase “right to health” by referring to non-discrimination on the grounds of race, religion, political belief, economic, or social conditions. Emphasis on non-discrimination in relation to health is reiterated in the following discrimination conventions.

- *Convention on the Elimination of All Forms of Racial Discrimination*²⁴

Article 5(e)(iv) provides that States Parties undertake to prohibit and eliminate racial discrimination in the enjoyment of “the right to public health, medical care, social security and social services.”

- *Convention on the Elimination of All Forms of Discrimination Against Women*

Article 11(l)(f) provides that States Parties shall take all appropriate measures to eliminate discrimination against women in the enjoyment of “the right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.”

Article 12 of the same convention provides that all appropriate measures should be taken by States Parties 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.”

The *Additional Protocol of the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador)*²⁵ uses the precise language “right

to health." Article 10, entitled "Right to Health," reads: "(1) Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being. (2) In order to ensure the exercise of the right to health, the States Parties agree to recognize health as a public good...."

The American Declaration of the Rights and Duties of Man contains the following similar language:

Article XI: Every person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources.²⁶

As stated earlier, these provisions employ a wide variety of language: some use the terminology "right to protection of health" or "right to preservation of health": others intersperse additional language between the terminology of "right" and "health". Naturally, when a particular treaty or declaration is considered for application in a concrete case, the specific language of the provision involved should be referred to, rather than the more general concept of a right to health.

National Provisions

The constitutions of some states include provisions on the right to health. A few are cited here (the references in this section are not exhaustive).

Writing about the American Hemisphere, the editors of the PAHO study referred to earlier report that:

Twenty of the constitutions of the civil and socialist law countries of the Hemisphere do include a statement on the right to health and/or the duty of the State in regard to the health of the nation. A right to health is proclaimed in five constitutions; a right to health protection is found in eight others. All the socialist law countries proclaim both a right and duty; of the civil law countries, only Argentina, Colombia and Costa Rica do not have a direct reference to the duty of the State in regard to health.²⁷

The editors point out that none of the common law countries of the Hemisphere contains a reference to the right to health. This may be due to influence of the United States Constitution on the constitutional development in these countries, since that Constitution does not contain references to social rights.

The 1987 Philippine Constitution refers explicitly to the right to health. It provides:

(Article II, sec. 15): The State shall protect and promote the right to health of the people and instill health consciousness among them.

(Article II, sec. 16) 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.²⁸

Although they do not use the terminology, "right to health," the French and Japanese Constitutions contain provisions relevant to the right. Specifically, the Preamble to the 1946 French Constitution, reaffirmed in the 1958 Constitution, provides that the State "guarantees to all and notably to the child, the mother and the aged worker, health protection, material security, rest and leisure."²⁹ Article 25 of the 1946 Japanese Constitution provides "...In all spheres the State shall use its endeavours for the promotion and extension of social welfare and security and of public health."³⁰

Professor Ruth Roemer in PAHO's *The Right to Health in the Americas* has pointed out that:

The principal function of a constitutional provision for the right to health care is usually symbolic. It sets forth the intention of the government to protect the health of its citizens. A statement of national policy alone is not sufficient to assure entitlement to health care; the right must be developed through specific statutes, programs and services. But setting forth the right to health care in a constitution serves to inform the people that protection of their health is official policy of the government and is reflected in the basic law of the land.³¹

III. Relevance of Rights Discourse To Health Issues

What do human rights have to do with health issues? What does rights discourse add to consideration of complex technical, economic, and practical issues involved in health care and status? It was earlier stated that the concept of a right to health as a human right emphasizes social and ethical aspects of health care and health status, as these aspects are embodied in principles underlying all international human rights. With that in mind, a rights-based perspective on health is developed in this section by focusing on the following elements of all rights and applying them to health status issues:

- 1) Conceptualizing something as a right emphasizes its exceptional importance as a social or public goal. (Rights as “trumps.”)
- 2) Rights concepts focus on the dignity of persons.
- 3) Equality or non-discrimination is a fundamental principle of human rights.
- 4) Participation of individuals and groups in issues affecting them is an essential aspect of human rights
- 5) The concept of rights implies entitlement.
- 6) Rights are interdependent.
- 7) Rights are almost never absolute and may be limited, but such limitations should be subject to strict scrutiny.

Rights as Trumps

The use of rights language vis à vis social goals confers a special status on those goals. As Ronald Dworkin puts it, categorizing something as a right means that the right “trumps” many other claims or goods.³² A special importance, status, priority, is implied in categorizing something as a right. Therefore, the use of rights language in connection with health issues emphasizes the importance of health care and health status. To speak of a right to health does not mean that that right should always take priority over all other goods, claims, or other rights; but it does emphasize that health issues are of special importance given the impact of health on the life and survival of individuals.

In a seminal study, Henry Shue defines “basic rights” as those necessary for the enjoyment of all other rights.³³ For example, he regards the right to physical security and the right to subsistence as basic rights from which follow ancillary rights, such as those to unpolluted air and water, and to minimal preventive health care.

Conceptualizing health status in terms of rights underscores health as a social good and not solely a medical, technical, or economic problem.

Dignity as the Foundation of Human Rights

In the language of the Preamble to the Universal Declaration of Human Rights, “recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world.” The concept of rights grows out of a perception of the inherent dignity of every human being. Thus, use of rights lan-

guage in connection with health emphasizes that the dignity of each person must be central in all aspects of health, including health care, medical experimentation, and limitations on freedom in the name of health. The focus must be on the dignity of the individual rather than the good of the collectivity. The utilitarian principle is rejected by a rights approach. The greater good of the greater number may not override individual dignity.

For example, although medical experimentation may result in good for the general populace, it must not violate the dignity of the individuals subjected to it. The dignity of all must be respected—in particular, the dignity of society's most vulnerable elements: the poor, racial and ethnic minorities, disabled persons, the mentally handicapped.

The Equality or Non-Discrimination Principle

Equality or non-discrimination is a fundamental principle of human rights law,³⁴ and prohibition of discrimination is a leitmotif running through all of international human rights law. Article 2 of the Universal Declaration of Human Rights provides, "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." The major international covenants on human rights contain similar non-discrimination clauses. Specific international treaties have been adopted prohibiting discrimination on the basis of sex or race. The rights approach, with its emphasis on non-discrimination (including on the grounds of limited economic resources) implies rejection of a solely market-based approach to the social good of health care and health status. Cost-containment and cost-benefit analyses in the health care allocation remain important but need not be determinative in matters of social goals relating to health.

As the WHO Declaration of Alma-Ata on Primary Health Care states:

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.³⁵

It requires only cursory consideration to understand how

frequently equality and prohibition of discrimination is violated in many aspects of health status. In most countries, the health status of racial or ethnic minorities is far worse than that of the majority population. Environmental racism (the dumping of environmental wastes or governmental ignoring of pollution in areas inhabited by the poor) has been documented. Extensive discrimination against women in health care and health status is only beginning to be noted. Women's health issues have been given less attention in medical research; women's health problems have attracted less interest than those from which men suffer; and many common cultural practices affect women more negatively than men. Dr. Jonathan Mann has pointed out that societal discrimination and lack of respect for fundamental human rights directly affect the health status of the population. He suggests that

..the thinking that led to the Universal Declaration of Human Rights and its list of fundamental and inalienable rights may provide a more useful entry point into a thorough consideration of the "conditions in which people can be healthy" than the approaches traditionally used in medicine and public health.³⁶

Discrimination in relation to women's health is developed more fully in Section V of this paper.

Participation

Participation of individuals and groups in matters that affect them is essential to the protection of all human rights. Democracy and human rights are frequently linked in current rights discourse—and democracy means more than merely voting: it requires provision of information and informed participation.

WHO has recognized the importance of participation in health matters. The Declaration of Alma-Ata on Primary Health Care states, "The people have the right and duty to participate individually and collectively in the planning and implementation of their health care."

Entitlement

The concept of a right implies entitlement to the subject of that right. The Final Act of the Conference on Security and Cooperation in Europe (better known as the Helsinki Accords)

succinctly provides that individuals are entitled to “know and act on their rights.” Judge Buergethal has written that the “recognition of the right to health as an internationally guaranteed right...gives legal and political legitimacy to the claims for its enjoyment.”³⁷

This does not necessarily imply resort to lawsuits, which may not always be the best means of asserting rights. Indeed, in some legal systems, social rights are considered non-justiciable. Other measures may be resorted to, such as administrative agencies or tribunals or creation of the role of ombudsman to respond to citizens’ complaints. Audrey Chapman, in an American Association for the Advancement of Science publication on the right to health care, has commented,

A rights approach offers a normative vocabulary that facilitates both the framing of claims and the identification of the right holder. This means that the addressees of the rights or duty-bearers [governments]...have the duty to provide the entitlement, not to society in general, but to each member. This standing has very important implications for efforts to seek redress in cases where the entitlement is not provided or the right violated.³⁸

Interdependence of Human Rights

Human rights are interdependent. That is, particular rights may depend on other rights for their fulfillment. The right of freedom of association, for example, is closely related to that of freedom of expression. Many other examples could be cited. As has been frequently reiterated by human rights organizations, all human rights and fundamental freedoms are indivisible and interdependent.³⁹ Therefore, the right to health cannot be effectively protected without respect for other recognized rights. These include, in particular, both prohibition of discrimination, and the right of persons to participate in decisions affecting them.

Limitations on Rights

Rights are generally not absolute in national or international legal systems and may be subject to limitations on certain grounds. *Protection of public health* is one of the accepted grounds for which limitations are permitted in the International Covenant on Civil and Political Rights and in other human rights instruments. Under the Covenant, protection of public health is a permissible ground for limiting the rights to liberty of movement,

freedom of religion, freedom of expression and the right to freedom of association.⁴⁰ In point of fact, in various countries, quarantines and limitations on freedom of movement often have been imposed for public health reasons. There is a danger that such restrictions on rights may not be justified on health grounds. For example, health professionals have emphasized that, on health grounds, it is unjustified to impose quarantines, job discrimination, and restrictions on freedom of movement on persons who are HIV positive. Limitations on rights must be scrutinized to determine whether they are truly necessary. Under international human rights law, national decisions to limit rights may be overseen by international monitoring committees, which can require states to provide adequate justifications for rights limitations.

IV. Governmental Obligations and the Right To Health

What obligations to promote and protect the right to health are incurred by states through ratification of treaties? As the Scottish philosopher Tom Campbell notes, "Working out the specific implications of general statements of human rights is a necessary move if the rhetoric of human rights is to have a major impact on the resolution of social problems."⁴¹

The hearing on the Right to Health organized by the United Nations' Committee on Economic, Social and Cultural Rights (henceforth "ESC Committee") on 6 December 1993, referred to earlier, is one of the rare (possibly unique) occasions on which this question has been considered by a UN organ. The ESC Committee, which monitors implementation of the Economic Covenant,⁴² invited interested organizations and individuals to present their views on the scope of, and obligations relating to, Article 12 of the Economic Covenant. This article provides that States Parties "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." In addition to an extensive presentation by a member of the Committee and presentations by representatives of the WHO, some 20 organizations and individuals made presentations.⁴³

Presentations emphasized the following aspects which could serve as guidelines for definition of the right to health and the obligations of states:

- 1) Article 12's listing of the steps to be taken by States Parties to realize the right to health.
- 2) The importance of referring to specific goals and indica-

tors developed by WHO, particularly relating to Primary Health Care and the Goal of Health for All by the Year 2000.

- 3) Fundamental principles common to respect for all human rights: dignity, non-discrimination, participation, entitlement. In this regard, several speakers referred to the necessity of special concern for the health needs of vulnerable populations.

As with all other social and economic rights mentioned in the Covenant, the obligation of states under the Covenant to implement the right to health is a progressive obligation. A state is not required immediately and fully to implement the right, but only to “achieve progressively the full realization of the right” (Article 2). However, the states parties are required by Article 2 to “take steps” to achieve the right. Those steps necessary to achieve the full realization of the right to health are listed in the second paragraph of Article 12:

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

While these steps provide a starting point for understanding the obligation to respect the right to health, their generality makes it difficult to determine specific obligations involved. As pointed out by a number of speakers at the ESC Committee’s hearing on the Right to Health, it is appropriate to have recourse to the work of WHO to determine more specific means of reducing infant mortality, improving environmental and industrial hygiene and preventing epidemic and other diseases—as well as creating conditions to assure medical care. Several presenters at the hearing emphasized the importance of such environmental fundamentals as clean water and sewage disposal.

WHO has elaborated in considerable detail, in their program on Primary Health Care and Health for All by the Year 2000, the means that can be used most effectively by both economi-

cally developed and developing countries to achieve the "highest attainable standard" of health. Indeed, the editors of the PAHO study on *The Right to Health in the Americas* regard the program of Health for All by the Year 2000 as providing the most important guide thus far to a state's responsibilities to protect health. They write,

The goal of Health for All by the Year 2000 is, in fact, the most concrete and useful definition of the programmatic social right to health protection, and may more succinctly express the common view of the responsibility of the state for the health of its people.⁴⁴

The Primary Health Care approach is described in the Declaration of Alma-Ata, adopted in 1978 at an international WHO conference. The essential aspects of that approach may be summarized as follows:

- 1) an emphasis on preventive health measures (immunization, family planning) more than on curative measures;
- 2) the importance of participation of individuals and groups in the planning and implementation of health care;
- 3) an emphasis on maternal and child health care;
- 4) the importance of education concerning health problems;
- 5) high priority to be given in provision of health care to vulnerable and high risk groups, such as women, children, underprivileged elements of society;
- 6) equal access of individuals and families to health care at a cost the community can afford.

WHO has also prepared a list of global indicators relating to many issues of health status. Among them are indicators on percentage of GNP spent on health, the amount of international aid allocated to health, and percentage of the population covered by primary health care.⁴⁵

It is striking that the Primary Health Care Approach of the WHO emphasizes many aspects fundamental to any rights perspective, as outlined in the previous section: participation, equality, and concern for society's most vulnerable members.

WHO has also prepared a questionnaire to help member states determine how well they are implementing the programs of Primary Health Care and Health for All by the Year 2000.⁴⁶ Whereas WHO does not itself monitor implementation of such programs by member states, it nevertheless receives indications

from member states of their own implementation evaluations. The ESC Committee, on the other hand, is responsible for international monitoring of the right to health provisions of the Economic Covenant and has found useful the guidance provided by WHO goals and indicators.

It would be helpful if the ESC Committee and others attempting to determine governmental right to health obligations could draw on application of the right by other international and national organs. Unfortunately, there is as yet little precedent.

In 1993 the World Health Assembly of the WHO requested an Advisory Opinion from the International Court of Justice on the legality of the use of nuclear weapons, given their health effects. The ICJ fixed 10 June 1994 as the time limit for submission of written statements by WHO and its member states and subsequently extended the time limit to September 1994. The specific question addressed to the Court for an Advisory Opinion was,

In view of the health and environmental effects, would the use of nuclear weapons by a State in war or other armed conflict be a breach of its obligations under international law including the WHO Constitution?⁴⁷

Although the question does not refer to specific provisions of the WHO Constitution, the provision that "enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being," and the provision that "governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures," would seem relevant. If the Court renders an advisory opinion on this request we may have a major contribution to understanding some of the international legal obligations relating to health.⁴⁸

Another case drawing on application of the right to health occurred in 1985. That year, the Inter-American Commission on Human Rights found a violation by Brazil of the American Declaration of the Rights and Duties of Man's provision on the right to preservation of health. The Commission found that the Brazilian Government had failed to take timely and effective measures on behalf of the Yanomami Indians and had thereby violated, *inter alia*, Article XI of the American Declaration of the Rights and Duties of Man providing that "every person has the right to preservation of his health through sanitary and social

measures relating to...medical care, to the extent permitted by public and community resources."⁴⁹

In another example, a recent decision of a national Supreme Court concerns the invocation of a constitutional provision on the right to health. In the 1993 case of *Minors Oposa v. Secretary of the Department of Environment and Natural Resources (DENR)*,⁵⁰ the Supreme Court of the Philippines reversed a trial court that had dismissed a claim based on alleged violation of the Philippine constitutional provisions on health. (For the text of the constitutional provisions see National Provisions in section II above.) The case involved an effort to have logging licenses revoked because of environmental damage they allegedly caused. The Court found that a *prima facie* case had been made for violation of the constitutional provisions on health and the environment. The decision was particularly interesting because the Court found that a group of minors had standing to file a class suit of this nature on behalf of themselves and succeeding generations, on the basis of inter-generational responsibility. They also held that invocation of the constitutional provisions in the case did not constitute a political question. The Court set aside dismissal of the claim by the trial court. While concurring in the result, Judge Florentino Feliciano filed a concurring opinion stating that the constitutional provisions were not sufficiently precise to constitute a legal right and were rather a matter of constitutional policy. He thus invoked a common argument regarding general constitutional provisions relating to social and economic rights (and, as well, regarding general provisions on such rights in international instruments)—namely, that they are not susceptible to application in a court of law; they are not justiciable rights.⁵¹

It has been noted that the obligation of states to protect and promote economic and social rights involves three aspects: (1) the obligation to *respect*—not to violate the right directly by its actions; (2) the obligation to *protect*—preventing others from violating the right; (3) the obligation to *fulfill*—the necessity for the state to take measures necessary to ensure the right.⁵² In applying these obligations, it would seem that the state is obliged to do nothing directly to injure health, such as committing torture by state agents. The obligation to respect can conceivably be applied, as the WHO request to the ICJ for an advisory opinion implies, to use of nuclear weapons, given their devastating health

effects on the population. The obligation to *protect*—preventing others from violating the right—might be considered as obligating the state to control tobacco companies' promotion of tobacco use. Finally, the obligation to *fulfill* might be considered as requiring the state to adopt primary health care with all that it implies, including emphasis on preventive rather than curative measures.

A number of speakers at the December 1993 hearing on the right to health noted that, despite WHO's exemplary work in developing goals and indicators through the Primary Health Care Program and the program of Health for All by the Year 2000, the goals are far from being achieved. Much remains to be done to focus national and international attention on the promotion of the right to health.

V. Two Issues Concerning the Right To Health

Among the many issues involved in determining governmental obligations regarding the right to health, two have been selected for particular consideration in this section: (1) economic resources and (2) discrimination. In both instances, it is possible to develop specific governmental obligations relating to health status.

Economic Resources and the Right to Health

One of the common assertions relating to implementation of the right to health is the inability of poor countries to provide an adequate level of health care or to provide the economic development which is necessary for an adequate health system. The cost of health care has also become a problem in developed countries. These countries find the need for adequate resources obvious, but experience increasing difficulty providing adequate and universal health care. Obstacles to improving health within states are often misallocation of resources, inequity in health care, and inefficiency. The purpose of this subsection is to demonstrate that all states have obligations under international law with regard to the right to health and that measures that are not costly can be taken to improve health status.

1) All ratifying states have obligations under Article 12 of the Economic Covenant regardless of their degree of economic development.

Article 2(1) of the Economic Covenant, above, provides that each State Party undertakes to take steps for progressive realization of the rights enshrined in the Covenant "to the maximum of its available resources." This phrase has sometimes been interpreted erroneously to imply that states with very limited resources have no obligations under the Covenant. All countries, however, have at least some "available resources"—even if severely limited in comparison with other countries. Hence, under the Covenant all ratifying states are obligated to respect the right to health, regardless of their level of economic development. The same paragraph of the Covenant also refers to the possibility of states calling upon international assistance to achieve respect for the right to health.

In 1986, a group of distinguished experts in international law adopted "The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights" at a meeting convened by the International Commission of Jurists, the Faculty of Law of the University of Limburg and the Urban Morgan Institute of Human Rights, University of Cincinnati.⁵³ The Principles specify that "The obligation of progressive achievement exists independently of the increase in resources; it requires effective use of resources available." (Article 23) They also assert that states parties are obligated "regardless of the level of economic development, to ensure respect for minimum subsistence rights for all" (Article 25) and that "resources available" refers to "both the resources within a State and those available from the international community through international cooperation and assistance." (Article 26) Of course, the specific obligations of a country will vary depending on resources.

2) *Improved health contributes to economic growth.*

The World Bank devoted its 1993 Report on World Development (*Investing in Health*) to the importance of health issues in economic development. The Report concluded that:

Improved health contributes to economic growth in four ways: it reduces production losses caused by worker illness; it permits the use of natural resources that had been totally or nearly inaccessible because of disease; it increases the enrollment of children in school and makes them better able to learn; and it frees for alternative uses resources that would otherwise have to be spent on treating illness.⁵⁴

Investing in health, therefore, is a means for a developing country to promote its economic growth, and justifies the priority given to it. Developing countries should therefore be concerned with placing importance on health issues because, *inter alia*, it makes sound economic sense.

3) *There is no automatic link between resources and health status.*

It is obvious that, while promoting health contributes to a country's economic development, a lack of resources often correlates with poor national health. The health of citizens in low- or middle-income countries is, in general, far worse than that in high-income countries. Child mortality rates are roughly 10 times higher than those in the established market economies, life expectancy is far lower, death rates among children are far higher. Facts and figures on the extent of malnutrition and health problems in many developing countries are staggering.

Nevertheless, the correlation between a lack of resources and poor national health does not always exist. Certain low- and middle-income countries show considerably better health statistics than other developing countries. Thus, citizens of Sri Lanka in 1991 had a life expectancy at birth of 71 years—nearly the same as that for many high-income countries and much higher than the average for other low-income countries. Citizens of China had a life expectancy at birth of 69 years—also a figure much higher than that of other low-income countries.⁵³ So, we see that factors other than income level are significant in terms of health status.

WHO has pointed out that “merely to increase incomes will not guarantee health. While there is a close relationship between health and income at the very lowest income levels, as incomes begin to rise health hazards associated with economic development begin to emerge.” Moreover, there is a difference in statistics relating to health status among high-income countries. In 1991, the United States had an infant mortality rate of nine per 1,000 live births, while the rate for Japan and Switzerland was considerably better at five per 1,000 births.

4) *Cost-effective means of promoting health.*

Given the shortage of resources in developing countries and the increasing cost of health care in high income countries,

special attention should be focused on the most effective use of resources to increase the level of health in both poor and rich countries.

WHO, in its *Global Strategy for Health for All by the Year 2000*, provided guiding principles that a State should follow to achieve its most cost-effective means of improving health status: (1) emphasis on preventive, rather than curative, health measures and (2) adoption of primary health care as the basic orientation of health policy. Failure to do so, according to WHO, constitutes misallocation of health resources. Of course, as mentioned earlier, these general statements must be converted into practical measures. Some cost-effective means for promoting health enumerated by WHO and by public health experts include:

- 1) emphasis on preventive rather than curative measures;
- 2) promotion of breast-feeding;
- 3) discouragement of tobacco use.

In a given population, many health expenditures lead to relatively little increase in health status of the population. This results in an emphasis by international organizations on increased expenditures for preventive rather than curative measures. WHO has reported,

...most conventional health care systems are becoming increasingly complex and costly and have doubtful social relevance. They have been distorted by the dictates of medical technology and by the misguided efforts of a medical industry providing medical consumer goods to society.⁵⁶

The World Bank has stressed that,

Governments in developing countries should spend far less—on average, about 50 percent less—than they now do on less cost-effective interventions and instead double or triple spending on basic public health programs such as immunizations and AIDS prevention and on essential clinical service.⁵⁷

An aspect of maternal and child health that has been consistently emphasized by WHO, most recently by the 1993 *World Development Report*, is the importance of breast-feeding. Considering it one of the most cost-effective means of increasing the health status of a population, WHO has not only devoted a great amount of attention to the promotion of breast-feeding, but has

also, together with non-governmental organizations and scientific and medical organizations, developed and promoted the International Code of Marketing of Breast-Milk Substitutes. This restricts certain marketing practices used to sell breast-milk substitutes in order to promote breast-feeding.

Because of the emphasis on developing countries during adoption of the International Code, it has been overlooked that breast-feeding is an important health issue in high-income countries. A 1991 study in the United States points out, for example, that that country's decline in breast-feeding in recent years is a dangerous trend.⁵⁸

Another cost-effective means of promoting health, according to WHO and to public health experts, is smoking cessation. It has been estimated that if current tobacco consumption trends continue, about 150 million children alive today will die of tobacco-induced diseases.⁵⁹ Evidence overwhelmingly suggests that tobacco smoking is the major cause of lung cancer, and is an important cause of cancers of the oral cavity, upper respiratory and digestive tracts, and bladder. Smoking has been reported as a cause of low birth weight of infants. In light of these facts, states that have undertaken a commitment to the right to health through ratification of the Covenant should adopt measures to discourage tobacco use. These could include restrictions on advertising of tobacco products; taxes on sales of tobacco products; and educational programs on detrimental effects of tobacco consumption. Growth of tobacco should be discouraged and, if possible, adverse economic consequences be compensated by economic measures (in the case of developing countries, possibly by assistance from international organizations). It should be noted that certain high-income countries adopt measures to discourage tobacco use of in their own countries, yet encourage exportation of tobacco to other countries, including developing countries, through export subsidies.⁶⁰ This constitutes an egregious violation of the right to health.

These cost-effective measures are only a few of those that should be taken by all countries—both developed and developing—to limit the cost of improved health care and health status. Even states with limited resources could take these measures to fulfill their obligation to respect the right to health.

Non-Discrimination: Women's Right to Health

Discrimination against women, in various forms, is nearly universal, although more severe in some countries than others. This widespread societal discrimination has serious consequences for the health of women and children—and therefore, for societies as a whole. The role of women in society demonstrates that one of the most effective ways of improving a nation's health is through educating its women.

WHO has provided an invaluable guide to women's right to health in its recent publication, *Human Rights in Relation to Women's Health: The Promotion and Protection of Women's Health Through International Human Rights Law*.⁶¹ Prepared by Professor Rebecca J. Cook, it surveys widespread discrimination against women and cites the resulting negative impact, not only on the health of women, but also on entire communities. In addition, the publication fully analyzes states' obligation under international human rights law to protect the health of women.

Throughout the world, discrimination against women takes many forms: inequity in pay, educational disadvantages, and cultural factors giving women a lesser role in the community. Many health risks incurred by women are not incurred by men: e.g., domestic violence, female genital mutilation, lesser attention to women's health in medical research, problems in reproductive health, lack of education for family planning, and special health risks for women at work.

Cook cites the Economic Covenant and the Women's Convention as setting general guidelines for the protection of women's right to health, but looks to WHO's women's health indicators and criteria to interpret obligations in the two treaties. Indicators of health status (such as statistics on longevity and provision of health services) may be used to determine whether a state is meeting its obligations to promote the right to health. As Cook points out, however, most statistics are not disaggregated according to sex and regions. Hence, for example, it may be impossible to determine whether health services in a particular country are reaching women in rural areas. For this reason, both WHO and UNICEF have stressed the need for disaggregation of health statistics.

Cook also points out that the states' obligation to respect health may require both negative and positive action on their part. For instance, a state *should not* obstruct access to informa-

tion regarding sources of HIV infection, but *should* undertake a public education program to provide that information. Women's rights to freedom from discrimination, to survival, to liberty and security of person, to family life and private life, and to education are all closely related to their rights to health and health care.

The obligation to respect women's health is discussed in relation to the right to life. Cook points out that,

This right has traditionally been discussed only in the context of the obligation of states parties to ensure that courts observe due process of law before capital punishment is imposed. This understanding of the right to life is essentially male-oriented, since men assimilate the imagery of capital punishment as more immediate to them than death from pregnancy or labour. Feminist legal approaches suggest that this interpretation of the right ignores the historical reality of women, which persists in regions of the world from which come almost all of the 500,000 women estimated to die each year from pregnancy-related causes...⁶²

A number of suggestions are made in this WHO publication regarding the obligations of states to respect women's health. Access to information on family planning, elimination of spousal authorization for certain health services, prohibition of involuntary sterilization, and emphasis on the importance of informed consent to therapeutic interventions are pointed out as being important means of protecting women's health.

WHO has established a Commission on Women's Health, which will continue the effort to define the specific content of the right to health as it relates to women. WHO can make a substantial contribution to the efforts of the ESC Committee and other human rights organs to implement the right to health. This study by Professor Cook is an excellent contribution to those efforts.

Conclusion

Health issues recently have attracted major national and international attention. They have been perceived as significant aspects of economic development, environmental issues, and the rights of children—all currently important international concerns. In point of fact, the World Bank devoted its entire 1993 World Development Report, *Investing in Health*, to the relation of health

to economic development. The Report emphasized the appalling discrepancy between health status of rich and poor countries, and underscored the need for attention to health status and health care in matters of economic development. In addition, UNICEF's annual reports on the State of the World's Children emphasize the necessity for improving the health of children in all countries. At the 1991 World Summit on Children, many of the goals agreed to by States centered on health concerns.

The Rio Conference on Environment and Development brought environmental issues to the fore internationally, and environmental advocates have since focused considerable attention on health issues arising from environmental pollution. WHO and UNICEF have been primarily responsible for focusing international attention on health issues.

Despite these gains, the binding legal obligations in relation to health have not been sufficiently recognized and emphasized. The 1993 World Development Report, for example, makes no reference to legal obligations concerning the promotion of health. Some of the reasons for the failure to refer to legal obligations concerning health have been developed in this paper: lack of clarity in the meaning of the obligations, paucity of national and international decisions defining the right, and the relative newness of the concept of the right to health. Nevertheless, the legal obligations need to be recognized and an effort made to spell out their implications.

Development experts, human rights activists and scholars, international organization personnel, and public health experts should collaborate in the effort to further define the scope and legal obligations of the right to health. WHO and UNICEF could make significant contributions. This suggestion presupposes that the concept of a "right to health" has much to offer in the protection and preservation of the health of the world's citizens.

The editors of the PAHO publication on *The Right to Health in the Americas* have emphasized the inter-relationship of law and health issues. In the Editors' Preface expressing the aims of their study, they write:

The purpose of this book is twofold: first, to contribute to a better understanding among lawmakers of the importance of a right to health; and second, to promote a greater awareness among health professionals of the role of law in health. It was hoped that in setting forth the importance of a right to health,

lawyers—whether or not they were familiar with the law of international human rights or the importance of health in the modern world—would be enlightened as to the critical nature of this issue. At the same time, it was expected that health professionals would learn the importance of law to the practice of their profession and would become more sensitive to and aware of the consequences of what are, essentially, legal choices.⁶³

It has been possible in this article only to sketch some of the many issues connected with the right to health. Numerous other issues relating to the subject remain to be considered. Although the paper discusses issues of women's health and discrimination, there are equally serious issues relating to discrimination in health matters against racial minorities and other vulnerable groups. There is overwhelming evidence of the serious differences in health status among various populations in countries based on ethnic differences. Some of the other questions that need to be examined in relation to the right to health are traditional practices affecting health; medical experimentation; problems concerning medical manpower; discrimination; AIDS; and conflicts between the right to health and other rights.

While the right to health has been discussed in this essay from the legal point of view, it is a concept that requires a multi-disciplinary approach. The international organs called upon to monitor the right to health, recognized in international treaties, must be able to draw upon the knowledge of those trained in the health disciplines.

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"The courts are much more aware of and attentive to their obligation to implement socio-economic uplift programmes and to ensure decent welfare for all. The state has a duty to all citizens to adhere to that part of the Constitution which describes the directive principles as 'fundamental' to the governance of the country. The courts have therefore been using the directives as an instrument to determine the extent of public interest in order to limit the extension of fundamental rights. In doing so they have upheld a number of statutes on the grounds of public interest, which in other circumstances may have been nullified." De Villiers, "Directive Principles of State Policy and Fundamental Rights: The Indian Experience," 8 *South African Journal on Human Rights* 29 (1992). See also Brian Walsh, "Existence and Meaning of Fundamental Rights in Ireland," 1 *Human Rights Law Journal* 171 (1980); Craig Scott and Patrick Macklem, *Constitutional Ropes of Sand or Justiciable Guarantees? Social Rights in a New South African Constitution*, 141 *University of Pennsylvania Law Review* no. 1, 1, (November 1992).

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