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The Right to Health as an Emergent Human Right

Several years ago I made a presentation at a faculty seminar at the Human Rights Institute of the University of Connecticut on the topic of the impact of globalization on the right to health. As I began, one member of the seminar group inquired, "Oh, is there such a thing as a right to health?" I was initially stunned. My questioner was a senior scholar in the human rights community who was well aware that a series of major international human rights instruments, most importantly Article 12 of the International Covenant on Economic, Social and Cultural Rights (1966), enumerate "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health," which is often shorthanded as a right to health. Other international human rights instruments apply the requirements of the right to health to specific communities and groups. There are also health-related human rights provisions in regional human rights instruments and in many countries' constitutions. So from a legal perspective there was no question that a right to health existed.

As I reflected on the exchange, I realized that I was most likely being teased, especially since I was well known to be a passionate advocate of the right to health and to be someone who had done extensive work on aspects of the right, but it set me to thinking about the implications of the query. To what extent does legal enumeration in international and regional human rights instruments and constitutions accord the right to health a reality and substance? Legal positivists generally find the recognition of a right in a key legal document sufficient to affirm its validity, and many in the human rights community take this position. Currently nearly all countries have ratified or acceded to at least one of the international human rights instruments that have enumerated the right to health, thereby becoming legally bound to implement the rights and principles stipulated in them. Currently, some 160 countries have ratified the International Covenant on Economic, Social and Cultural Rights, among them the major western democracies with the exception of the United States. Moreover, an increasing number of nonstate actors, including humanitarian organizations and charitable funders, are now being guided by human rights norms as they seek to improve health access and outcomes (Gable 2007).

Nevertheless, I soon acknowledged that there are other important requirements if a human right is to have a reality and a substance, and the right to health does not fulfill all of them. That the vast majority of states have ratified or acceded to at least one of the major human rights instruments that enumerate a right to health does not mean they fulfill the requirements specified therein or even make a serious effort to do so. There is a vast disparity between rhetorical affirmations of various rights and their implementation. Although under international human rights law, ratification of human rights instruments imposes binding legal obligations, many states consider the requirements stipulated in the international human rights instruments that they have ratified, particularly those in the sphere of economic, social, and cultural rights, to be more in the nature of aspirational goals or perhaps even optional. While international human rights bodies have developed expansive interpretations of specific rights over time, including the right to health, many states have far more minimalist conceptions of what these rights entail. My experience in dealing with government officials in several developing countries also suggests that the policymakers with control over relevant subject areas covered by specific human rights instruments may not even be aware of the country's human rights commitments, let alone their policy requirements. Moreover, one influential country, the United States, has neither ratified the International Convention on Economic, Social and Cultural Rights nor acknowledged the legitimacy of human rights to health or health promotion.

The Right to Health as an Emergent Right

The right to health can be understood as an "emergent" human right. Richard Hiskes, who originated this terminology, employs the concept to justify the establishment of a new human right to a safe environment (2005). Unlike the right to health, the human right to a safe and/or healthy environment is not as yet enumerated in a major binding international human rights instrument. Hiskes argues that preservation of clean air, water, and soil for current and future generations requires the "muscular conception" of human rights (2009, 1–2), and therefore the right to safe environment should be recognized as a human right. Like other political and human rights theorists, most particularly Henry Shue (1980), Hiskes links the development of new human rights to the perception of serious or

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"standard threats" widely affecting members of a society that are acknowledged to require a collective response (2009, 43–47). Hiskes believes that new emergent risks that pose significant harms, particularly environmental pollution, degradation, and damage, similarly require a rights response (2009, Chapter Two).

So in what sense can the right to health be considered an emergent right? First, the articulation of health and health care as the subject of human rights and the inclusion of the right to health in major international and regional human rights instruments occurred relatively recently, especially in comparison with the civil and political rights that can trace their heritages back to the natural rights traditions in the seventeenth and eighteenth centuries. Second, the right to health initially attracted limited recognition but its standing and legitimacy has grown over time. Third, the interpretation of the right and the understanding of the related obligations have developed gradually. And fourth, implementation of the various dimensions of this complex right has been a slow process often dependent on a supportive environment, and in the last three decades the process has been challenged by the dominant neoliberal paradigm.

Although the term "emergent" suggests a unidirectional evolution toward a clearer conceptualization of the requirements of a specific human right and greater support, this is not necessarily the case. Emergent can also refer to ways a right confronts and adapts to major challenges and opportunities in its environment. This book argues that in contrast with the post–World War II environment in which the right to health was initially framed and incorporated in major international human rights instruments, the more recent international economic, political, and health landscape presents significant risks and challenges to the protection of health and the implementation of the right to health. These challenges include the diminishing support for the welfare state, the rise of neoliberal approaches to health policy prescribing privatization and commercialization of health institutions, the globalization of health and the economic order, and the influential role of transnational corporations in the pharmaceutical sector and the political and economic order. Additionally, new understandings of the importance of the social determinants of health call for refocusing elements of the right to health and a greater use of the findings of social medicine and social epidemiology.

The contemporary environment presents new opportunities as well. The widespread global commitment to achieving universal health coverage – at least in rhetoric – one of the key dimensions of the right to health, provides human rights advocates with an opening to identify what universality requires from a human rights perspective and to work with policymakers and other civil society groups toward its realization. However, whether the current economic and political landscape and its adverse impacts make universal health coverage a broadly feasible goal consistent with human right requirements is an important question.

If the goal of adopting a human rights approach is to influence policy development, as I believe it should be, it becomes even more important to understand the contemporary health landscape and policy environment. It does not make sense to advocate for the adoption of a right to health without contextualizing the requirements of doing so. Nor can a right to health be implemented without taking the challenges it confronts into account and developing a strategy for overcoming them.

Recognition of Health as the Subject Matter of a Human Right

Although health has long been valued both as an intrinsic good, valuable in and of itself, and as an instrumental good required for many of life's undertakings, the recognition of health as the subject matter of a human right is a relatively recent development. In the seventeenth century, the philosopher René Descartes wrote in his *Discours de la Méthode* "the preservation of health … is without doubt the first good and the foundation of all other goods in this life" (Descartes 1637, 1953, 168 quoted in Anand 2004, 17). Health is widely perceived as essential to human flourishing because it enables a person to pursue the various goals and projects in life that she or he has reason to value (Anand 2004, 17–18). Norman Daniels's well-known interpretation attributes the special moral importance of health to its contribution to the range of exercisable or effective opportunities open to each person. Or to put the matter another way, meeting health needs allows people to choose among the life plans they can pursue given their talents and skills (Daniels 2008, 21). In another widely cited account, Martha Nussbaum identifies good health, including reproductive health, as one of the essential human capabilities necessary for leading lives that are fully human. She argues that the structure of social and political institutions should be chosen, at least in part, with a view to their ability to promote health at a minimum threshold level of capability for all members of society (Nussbaum 2000, 75–78). Summarizing why governments should take health more seriously, Richard Horton, the Editor-in-Chief of *The Lancet*, a leading medical journal, states that "Health policies matter because they underlie the fundamental commitments of governments to the dignity of their people. Health matters because when politicians intervene in health policy they are intervening not with our health, but with the futures we all value and long for" (2013, 980).

Health services and health systems are also considered to have ethical import for their role in protecting fair equality of opportunity (Daniels 2008, 57) and to be important social goods for their roles in the prevention of death and disability, the relief of pain and suffering, and the restoration of functioning. Beyond these tangible benefits, the association of health care with meaningful and memorable aspects of personal life – birth, illness, and death – adds a symbolic dimension. Because all human beings are vulnerable to disease and death and many health problems are beyond their control and therefore undeserved, health care also has special interpersonal significance through expressing and nurturing bonds of empathy and compassion (President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research 1983, 11–12). It has also been noted that concepts of health care are embedded in the moral visions and commitments of a society. Or to put it another way, "a society's commitment to health care reflects some of its most basic attitudes about what it is to be a member of the human family" (President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research 1983, 17).

Given the ethical import of health and health care, the health system should be viewed as central to the fabric of social and civic life. A variety of ethicists and human rights scholars characterize health systems as a core social institution, akin in many respects to the key roles of the judicial system in a democratic political system, and not simply a delivery point for biomedical interventions (Freedman et al. 2005, 19–20; Backman and Hunt 2008, 82; Yamin and Norheim 2014, 299). The characteristics and capabilities of health systems communicate and embody the values and norms of a society both through the interpersonal relationships and in the very structure of the health system. People's interaction with the health system defines in central ways their experience of the state and their place in the broader society (Freedman 2005, 21).

In the past sixty years, health status and access to health care have become the subject of a special kind of ethical claim: they have been recognized as the subject matter of human rights. Human rights differ from other types of ethical claims in several important ways. A distinctive value of human rights, which differentiates it from other moral discourses, is that rights confer specific claims or entitlements on right holders and give the right holder the grounds to press these claims if enjoyment of the right is threatened or denied (Freeman 2002, 61). In the case of a human right, these claims are considered to be universal, that is, vested in all persons

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in every society by virtue of their shared humanity. Respect for human dignity is the grounding of the human rights paradigm. Because rights are considered to be universal, characteristics such as nationality, race, sex, and economic and social position become irrelevant. Indeed nondiscrimination on any of these grounds constitutes a fundamental human rights principle. Designating something as a human right accords it a special normative status: while not absolute or exceptionless, a human right is considered to take priority over other moral, legal, and political claims (Nickel 1987, 3). In contrast with other types of ethical standards, human rights incorporate a stronger standard of accountability. A right is socially guaranteed and as such necessitates correlative duties – for individuals to respect them and for governments to take positive measures to protect and uphold the obligations they encompass (Nickel 1987, 3). A human rights approach also seeks to promote active agency by rights holders, particularly by those individuals and groups vulnerable to human rights violations, and to develop an active civil society shaping, prioritizing, and overseeing implementation (London 2008).

This book refers to health and human rights in two different ways. The first is a right to health that confers a legal entitlement. The second is human rights-based approaches to health, often shortened to rights-based approaches to health. A human rights-based approach has been defined as "a conceptual framework that is normatively based on international human rights standards and operationally directed to promoting and protecting human rights" (Backman 2012, 20). As such it is a potentially relevant standard for all countries that claim to respect international human rights standards. Human rights-based approaches offer a set of norms or principles, many derived from the Universal Declaration of Human Rights (United Nations 1948), relevant to the framing, implementation, and evaluation of health policies. In contrast, a right to health, or more precisely to the enjoyment of the highest attainable standard of physical and mental health, refers to specific entitlements, requirements, and obligations enumerated in a specific human rights instrument, such as the International Covenant on Economic, Social and Cultural Rights (ICESCR or the Covenant).

According to Amartya Sen, to frame a moral claim as a human right implies that it is of special importance and it is subject to social influence (2004). From the above discussion, it is clear that health and health care are widely considered to be of special importance, and many would add of special moral importance. Additionally, the fields of social epidemiology, social medicine, and medical sociology have shown that health and

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the opportunities to lead healthy lives are significantly influenced by what is termed the social determinants of health, the conditions in which people grow, live, work, and age (Commission on the Social Determinants of Health 2008). Or to state this in another way, “people’s health or clinical ‘health outcomes’ and their antecedent capabilities to be healthy are significantly socially produced (i.e., nurture, protected, restored, neglected or thwarted) by a range of political, economic, legal, cultural and religious institutions and processes operating locally, nationally and globally” (Venkatapuram 2011, 3). I would add a third set of conditions for something to become the subject matter of a human right, the shared belief that the subject matter is a high priority social good to be collectively promoted and protected.

For the right to health these preconditions were not met until after World War II and in some countries more recently, and in still others, including the United States, not at all. Historically the health of populations and the availability of health care were not considered to be a major governmental responsibility, with the exception perhaps of measures taken to improve sanitation (Toebes 1999, 8). While health was valued as an important and beneficial asset, it was assumed to be in the private rather than the public or social domain. Until the nineteenth century little was understood about the cause of disease or of effective prevention and treatment measures. Before the development of scientifically grounded medical practice, much of health care could be provided by lay people rather than by professionals. Over the centuries, families, private charities, and religious organizations cared for the sick and dying, usually without any assistance from the public sector (President’s Commission for the Study of Ethical Problems in Medicine and Biomedical Research 1983, 12–13).

Greater governmental involvement in health policy initially dated to the second half of the nineteenth century. The initiation of national welfare and health policies is usually associated with the reforms of Otto von Bismarck, the German chancellor from 1862 to 1890, who enacted a sickness insurance program together with retirement and disability benefits and a workers’ compensation program. This development was originally motivated by the goals of achieving a more productive labor force, fostering a healthier general populace, and ameliorating social unrest, not investing individuals with social welfare benefits. By the end of the century many countries in Europe had some form of health insurance although most of them were not as comprehensive in form as Bismarck’s program (Callahan and Wasunna 2006, 88).

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Health or health care became the explicit subject matter of a human right following World War II. Like other social and economic rights, the framing of a right to health or health care reflected an expanded sense of government responsibility for the welfare of its citizens consistent with the emergence of the modern welfare state. The deprivations of the great depression, the devastation of World War II, and the atrocities of the Holocaust served as catalysts for this to occur.

The social safety net and welfare policies introduced after World War II also reflected new expectations as to what people should expect from the state. Changed relationships among members of the society and their relationship with their government are captured in the notion of social citizenship. Social citizenship "connotes a relationship of members of society to each other through the state that recognizes a positive obligation of the state to ensure the conditions exist for the realization of the shared dignity of all human beings" (Cameron 2007, 163). Others have associated this transformation in social relationships with the concept of solidarity, a kind of communal or communitarian moral premise. According to Daniel Callahan and Angela Wassuna, the principle of solidarity "encompasses the mutual responsibility of citizens for the health care of each other, equitable access to care, and it assumes that, in the face of illness and the threat of death, we are bound together by common needs that require a community response" (2006, 90). Callahan and Wasunna also claim that the concept of solidarity and not a commitment to human rights underlies support for universal health care, at least in Europe (2006, 90). However, it is more likely that solidarity is complementary with and strengthens a human rights approach.

The development of social and economic rights required a new understanding of human rights. In the traditional liberal approach to civil and political rights enumerated in documents like the United States Bill of Rights, rights are conceptualized primarily as restrictions on the state's power and as such confer a negative duty on the state not to act in ways that infringe an individual's rights. In contrast, social and economic rights, such as the rights newly identified in the Universal Declaration of Human Rights (United Nations 1948), entail positive obligations for the state to fulfill with resource and distributive consequences (Flood and Gross 2014b, 451–452). Health and health care as the content of a human rights entitlement are among the rights enumerated in the Universal Declaration. Article 25 stipulates that "everyone has a right to a standard of living adequate for the health and well being of himself and of his family, including food, clothing, housing, and medical care and necessary social services …"

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The 1966 International Covenant on Economic, Social, and Cultural Rights constitutes the first enumeration of the right to health in an international human rights instrument legally binding on the countries that ratify the document and thereby become a state party to it. Article 12 mandates that the steps to be taken to achieve full realization of this right shall include those necessary for "(a) provision for the reduction of the stillbirth rate and 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; and (d) the creation of condition which would assure medical services and medical attention to all in the event of sickness" (1966, Article 12 (2)).

Subsequently, other international human rights instruments, regional human rights conventions, and national constitutions have also enumerated the right to health. The International Convention on the Elimination of All Forms of Racial Discrimination (1965), the Convention on the Elimination of All Forms of Discrimination Against Women (1979), and the Convention on the Rights of the Child (1989) all have provisions relating to the right to health. Various regional human rights instruments also enshrine this right including the European Social Charter (1961), the African Charter on Human and Peoples' Rights (1986), and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (1988).

In addition, constitutions of many countries have relevant provisions. One survey found that two-thirds of national constitutions currently do so (Kinney and Clark 2004), but not necessarily in the form of an explicit legal entitlement. Some constitutions have a provision addressing health or health care as a programmatic statement, for example, as a directive for state policy. The establishment of a constitutional right to health appears primarily in newer constitutions of emerging democracies. In contrast, countries with stronger public health systems providing a wider range of health entitlements are often older established democracies in which the health care system developed in the context of a welfare state without explicit reference to health rights (Flood and Gross 2014a, 5)

Status of the Right to Health

The status of the right to health has in large part reflected the manner in which social and economic rights are viewed. Economic and social rights have confronted a struggle for acceptance on the same basis as civil and political rights, especially in the Anglo-American countries. Importantly, the stature and visibility of the right to health have improved over time.

The watershed decision to incorporate social and economic rights in the Universal Declaration of Human Rights was not without controversy, but studies of the drafting history of these provisions show there was considerable support for doing so (Morsink 1999; Whelan 2010). It is true that the text approaches social and economic rights differently from the civil and political rights enumerated in the Universal Declaration. Economic and social rights are accorded to everyone as a member of society, and not on an individual basis as the civil and political rights enumerated are, and unlike civil and political rights, social and economic rights are conditioned on the organization and resources of each state, as augmented by international cooperation (Article 22). Johannes Morsink, the author of a study of the drafting history of the Universal Declaration, contends that this phrasing reflects efforts by the drafters to call special attention to social and economic rights because they were so new and not because they considered them to be less important than the older civil and political rights (Morsink 1999, 334).

However, after the cold war began, the reservations of representatives of the United States government and, to somewhat lesser extent, European governments increased. In post–cold war international forums, U.S. officials frequently denigrated the standing of social and economic rights because of their perceived association with socialism and the Soviet bloc. This interpretation of the origins of economic and social rights has been disputed by some scholars who trace them back to President Franklin Roosevelt's Four Freedom's speech in 1941 (Whelan 2010, 25–26). This may be historically correct, but when economic and social rights were championed by the Soviet bloc it stimulated U.S. opposition.

Despite the human rights community's rhetoric of the indivisibility, interdependence, and interrelatedness of all human rights, economic and social rights have often been considered to be inferior to civil and political rights. A categorization of three generations of human rights put forward by Karel Vasak in 1977 to explain differences in the historical development and bases of various types of human rights was widely adopted, but not for the purposes Vasek intended. The language of generations, originally meant to reflect the historical development of the rights, became translated into status differences. First generation civil and political rights came to be considered more significant and to be more important. Until recently, even the United Nations human rights apparatus invested less attention