The Right to Health in International Law – Normative Foundations and Doctrinal Flaws

A. Katarina Weilert[*]

Abstract

The human right to health is a highly complex right. The broad conception of health as devised in the preamble of the Constitution of the World Health Organization amounts to a moral and political claim, but cannot form the basis of a legal right to health. This contribution briefly introduces different sources of the right to health and identifies Article 12 of the International Covenant on Economic, Social and Cultural Rights as the central norm, which is examined in greater detail. The structure of the right to health is challenging in various dimensions: First, the right to health, although considered amongst social rights, combines aspects from all three generations of human rights. Second, it often serves as an umbrella right and loses its distinctiveness as virtually everything can have an impact on a person's health. Third, the right to health is a hybrid right combining elements of both an individual's as well as a public health approach. When it comes to infectious diseases, the individual's rights can clash with a public health-strategy. In this contribution, it is argued that the different aspects of the right to health should be better distinguished. As an individual human right, the right to health should be perceived in a narrower sense focusing primarily on medical care. As an obligation to promote public health, the human right to health can be seen in a broader context, embracing also the underlying determinants of health. Combatting infectious diseases is one of the main tasks within the obligations of states to promote public health. Public health cannot be measured in terms of the feasibility of individual legal actions, but should primarily be seen as a policy strategy (with different accountability structures), embracing national and international actors who need to be coordinated in terms of International Health Governance.

---

* Dr. (Freie Universität, Berlin), LL.M. (University College London), Senior Research Fellow at the FEST (Forschungsstätte der Evangelischen Studiengemeinschaft e.V., Protestant Institute for Interdisciplinary Research, Heidelberg). All websites last accessed on January 10, 2017.

I The Complexity of the Right to Health

International Health Governance (IHG) presupposes that the protection and promotion of health is not solely an issue of the internal affairs of a person's state of residence, but has a strong cross-border dimension. Out of the necessity to view health in international terms, two streams of reasoning prevail – the first arguing for health as a security issue and the second relating to health as a human right or moral obligation. Infectious diseases do not stop at borders and states and other actors have an interest to ensure that international traffic and trade, key features of the globalized world, are safe. Therefore, the first reason to consider health as an international issue is rooted in the interest of states concerning their security.[1] The second stream of reasoning, the human rights approach, focuses on the individual or on specific groups of human beings or the population as such, and thus establishes a moral, political and legal responsibility to promote the health of human beings within and across national borders.[2] This contribution provides an overview of the sources, content, inner structure and actual state of the right to health. Although in recent times literature and documents released by international institutions (such as the World Health Organization (WHO) and the United Nations Special Rapporteurs on the right to health) have increased on this topic, there are many open questions. To date, there is no unambiguous definition of health and the scope of a universal right to health. Furthermore, there is an intense debate on how to promote a legal

1 Compare the contributions of *Robert Frau*, "Combining the WHO's International Health Regulations (2005) with the UN Security Council's Powers: Does it Make Sense for Health Governance?" and *Ilja Richard Pavone*, "Ebola and Securitization of Health" in this volume. Toebes, B, "International health law: an emerging field of public international law" (2015), 55 *Indian Journal of International Law*, 299 (312 et seqq.) divides the scope of international health law into three categories as she considers "health and international trade" to be separate from "health security threats". Gostin, L O, "Global Health and the Law" (2014), 370 *New England Journal of Medicine*, 1732 (1732) speaks of "multiple spheres, ranging from national security, economic prosperity, and sustainable development to human rights and social justice".

2 Compare Ruger, J P, "Normative Foundations of Global Health Law" (2007-2008), 96 *Georgetown Law Journal*, 423 et seqq. which addresses legal, political and moral aspects of global health law; Hunt, P & Backmann, G, "Health Systems and the Right to the Highest Attainable Standard of Health" in Clapham, A & Robinson, M (eds.), *Realizing the Right to Health*, 2009, 40 (57) maintaining that the right to health "is the only perspective that is both underpinned by universally recognized moral values and reinforced by legal obligations".

and effective right to health instead of a mere political ideal. Moreover, there is no clear distinction of public (in the sense of population[3]) health strategies and an individual right to health.[4]

Despite its uncontested significance, for a long time health has not been perceived as a human right.[5] *Mahesh S. Poudel* notes that conventionally, people used to see health as being part of the private and not the public realm.[6] It seems that many people have not been used to the thought that there can be human rights claims and international responsibilities with regard to health.[7] There is also nearly unanimous agreement that there is no "right to be healthy", as health is dependent on many factors that are out of reach of a state or any other entity (for example genetic predispositions).[8] As health is most important for an individual's well-being and is the basis for pursuing other aims, it is a precondition for the enjoyment of other human rights.[9] If health is severely affected (as it was during the epidemic of

---

3 Compare Toebes, B, "Human rights and public health: towards a balanced relationship" (2015), 19 *International Journal of Human Rights*, 488. See also Tobin, J, *The Right to Health in International Law*, 2012, 54 ("[…] a level of moral agreement – not merely legal or political – still exists and is reflected in the social process that leads to the recognition of a particular interest, such as the highest attainable standard of health, as a human right").

4 Compare for the concepts of "individual rights" *ICJ LaGrand Case (Germany v. United States of America)*, ICJ Reports 2001, 466 para. 76 et seq. ("individual rights").

5 Bielefeldt, H, "Der Menschenrechtsansatz im Gesundheitswesen" in Frewer, A & Bielefeldt, H (eds.), *Das Menschenrecht auf Gesundheit*, 2016, 19 (20), speaks of a "Wahrnehmungsdefizit" (deficit of perception) with regard to the right to health; Poudel, M S, "Right to Health and Its Jurisprudence: An Overview" (2011), 5 *National Judical Academy Law Journal*, 215 (220): "The right to health is unquestionable part of international human rights law, but still many people do not grasp that it is a fundamental human right."

6 Poudel, "The Right to health", above Fn. 5, 218; compare also Riedel, E, *Right to Health, MPEPIL*, 2016, para. 1: Historically private entities (families, churches, charities) were predominantly responsible for fighting diseases, however, with respect to epidemics, state institutions were actively engaged.

7 Bielefeldt, "Menschenrechtsansatz", above Fn. 5, 51.

8 Bielefeldt, "Menschenrechtsansatz", above Fn. 5, 22 ("Kann es einen Rechtsanspruch auf Gesundheit im eigentlichen Sinne überhaupt geben und wer soll ihn garantieren?"); Riedel, E, "The Human Right to Health: Conceptual Foundations" in Clapham, A & Robinson, M (eds.), *Swiss Human Rights Book Vol. 3, Realising the Right to Health*, 2012, 21 (28); CESCR, *General Comment No. 14 on the right to the highest attainable standard of health E/C.12/2000/4*, para. 8.

9 CESCR, *General Comment 14*, above Fn. 8, para. 1; Riedel, E, "The Human Right to Health" in Clapham, A & Robinson, M (eds.), *Realizing the Right to Health*,

the deadly Ebola virus in West Africa from 2014-2016), the right to health can have overlaps with the fundamental right to life.

Human rights are usually divided into three so-called "generations":[10] (1) liberty rights and rights to participate in political life, (2) economic, social and cultural rights and (3) – debatable – group rights. The third category is only "emerging" and many questions are unsolved, for example whether a group can be a rights-holder at all.[11] Usually, the right to health is perceived to fall into the second category. However, the right to health combines – as will be shown later – aspects of all three generations as it includes freedoms and entitlements as well as a protection for vulnerable groups and the underlying determinants of health.[12] This adds to the non-specific structure of the right to health and forms part of its impediment to make the right more effective.

The right to health is framed as part of a catalogue of universal and fundamental rights. This means that generally every human being can refer to this right and that this right does not depend on any qualification of the individual or preliminary behavior or social role.[13] Since the right to health

---

2009, 21: "Health is a fundamental human right, indispensable for the exercise of many other human rights, and necessary for living a life in dignity." See also: Oldring, L & Jerbi, S, "Advancing a Human Rights Approach on the Global Health Agenda" in Clapham, A & Robinson, M (eds.), *Realizing the Right to Health*, 2009, 102: "There is broad agreement that health policies, programmes and practices can have a direct bearing on the enjoyment of human rights […]"; Poudel, "The Right to health", above Fn. 5, 220: "Health is a fundamental human right which is indispensable for the exercise of other human rights."

10 Today many authors claim that the difference between civil and political rights on the on hand and economic and social rights on the other hand is artificial, compare Kumar, C R, "Human Rights Crisis of Public Health Policy" (2012), 52 *Indian Journal of Int. Law*, 351 (355, 386).

11 The existence of group rights is highly disputed in international law as this dimension of rights faces many flaws. Compare for a general discussion Bisaz, C, *The Concept of Group Rights in International Law*, 2012; Bronwlie, I, *Principles of Public International Law*, 7th edition, 2008, 567. Compare for group rights in the "Banjul-Charta": Schaarschmidt, J, "Gruppenrechte als Menschenrechte? – Erkenntnisse aus dem afrikanischen Völkerrecht" in Junge Wissenschaft im öffentlichen Recht e.V. (ed.), *Kollektivität*, 2012, 97 et seqq. She maintains that group rights can be individual rights – individuals having a right as being part of the group – as well as group rights as such (113).

12 Compare Akhvlediani, M, "Right to Health Care in International Law" (2008), 1 *Saertâšoriso samartlis žurnali*, 236 (244).

13 Bielefeldt, "Menschenrechtsansatz", above Fn. 5, 25.

not only includes freedoms, but also entitlements to prevent diseases, restore health and provide for the underlying factors of health, the right to health has been criticized as being a mere political ideal. The tension between the claim of health as a universal and fundamental right and the notion that only (if at all) a basic protection can be provided for all people, is one of the great challenges and unsolved problems which will be dealt with in this contribution.

A further challenge of any legal framing of the human right to health is the problem that "health" itself is an imprecise term.[14] The well-known and manifoldly criticized[15] definition of the preamble of the WHO Constitution reads: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[16] This broad and controversial conception of health emphatically removes it from a mere medical connotation and views it in a larger social context.[17] There is an extended discussion among philosophers and social scientists around the definition of health, which cannot be mapped out here.[18] In international human rights law, health is usually conceived as a concept not being restricted to physical health, but also embracing mental health and furthermore being related to a "healthy" social and ecological environment. It is persuading to look at

---

14 Compare Akhvlediani, "Right to Health Care", above Fn. 12, 242.

15 Compare for a discussion on the definition of "health" Toebes, B, *The Right to Health as a Human Right in International Law*, 1999, 21 et seqq. (she suggests to abstain from any clear definition of "health" within the right to health).

16 Constitution of the World Health Organization, Preamble. The Constitution was adopted by the International Health Conference held in New York from June 19 to July 22, 1946, signed on July 22, 1946 by the representatives of 61 states (Off. Rec. Wld Hlth Org., 2, 100), and entered into force on April 7, 1948.

17 Compare for a discussion of the WHO definition of health: Toebes, "International health law", above Fn. 1, 303. See also Marmot, M, "Social Causes of Social Inequalities in Health" in Anand, S, Peter, F & Sen, A (eds.), *Public Health, Ethics, and Equity*, 2006, 37-61; Wikler, D, "Personal and Social Responsibility for Health" in Anand, S, Peter, F & Sen, A (eds.), *Public Health, Ethics, and Equity*, 2006, 109-134.

18 Huber, M et al., "How Should we Define Health" (2011), 343 *British Medical Journal*, d4163; Nussbaum, M, *Creating Capabilities: The Human Development Approach*, 2011; Sen, A, *Development as Freedom*, 1999; Venkatapuram, S, *Health Justice: An Argument for the Capabilities Approach*, 2011; Siegrist, J, "Gesundheitsverständnis und Verantwortung für die Gesundheit" in Weilert, A K (ed.), *Gesundheitsverantwortung zwischen Markt und Staat*, 2015, 53; Rothhaar, M, "Ansätze zur philosophischen Rechtfertigung eines Rechts auf solidarische Gesundheitsversorgung" in Weilert, A K (ed.), *Gesundheitsverantwortung zwischen Markt und Staat*, 2015, 243, 245 et seqq.

health in this comprehensive way. However, if it comes to the concept of a human right which creates clear legal obligations and shall ideally be enforceable, this conception of health causes great difficulties. The vast majority of people could likely be considered to be "not healthy" if they refer to the WHO definition as a model with which they compare their actual life. In addition to that, the full protection of human health is factually and legally impossible as "virtually every activity has some implications for human health".[19] Thus, this broad definition can be used as a political aspiration and as an ideal, but not as the basis of international obligations.[20]

The problems around the right to health as sketched in this introduction shall in the following be further examined by recalling the sources of the right to health and the content attributed to them (II), analyzing the tension of the individual's right to health and the collective right to public health (III), as well as a reflection on the content of the right to health (IV).

II Sources of the Right to Health

The right to health has been widely acknowledged in multilateral contracts and further international documents.[21] This contribution concentrates on the most important sources. It does not include regional instruments and conventions to maintain and improve health, such as Article 16 African Charter on Human and People's Rights ("Banjul Charter"), Article 11 and 13 Revised European Social Charter, Article 35 European Union Charter of

---

19 Tomaševski, K, "Health Rights" in Eide, A, Krause, C & Rosas, A (eds.), *Economic, Social and Cultural Rights*, 1995, 125, 127.

20 The WHO preamble is not legally binding, see Krennerich, M, "Das Menschenrecht auf Gesundheit. Grundzüge eines komplexen Rechts" in Frewer, A & Bielefeldt, H (eds.), *Das Menschenrecht auf Gesundheit*, 2016, 57 (59); Hestermeyer, H, *Human Rights and the WTO. The Case of Patents and Access to Medicines*, 2007, 113 (with further references). Under another view, the WHO preamble should be regarded as binding law, Toebes, *The Right to Health as a Human Right*, above Fn. 15, 33.

21 For a comprehensive overview see: Toebes, *The Right to Health as a Human Right*, above Fn. 15, 27 et seqq.; a shorter overview is provided by Riedel, "Human Right to Health", above Fn. 9, 22 et seqq.; Riedel, "The Human Right to Health: Conceptual Foundations", above Fn. 8, 22 et seqq.; Riedel, *Right to Health*, above Fn. 6, para. 6 et seqq.; Krennerich, "Menschenrecht auf Gesundheit", above Fn. 20, 58 et seqq. Compare for the question whether the right to health belongs to customary international law: Hestermeyer, *Human Rights and the WTO*, above Fn. 2120, 127.

Fundamental Rights and Article 10 Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights ("Protocol of San Salvador").[22] Rather, it focuses on the development of the universal human right to health and its content.

1 Origins at the United Nations and World Health Organization

The Universal Declaration of Human Rights (UDHR) of 1948[23], not legally binding in itself but largely accepted as part of international customary law,[24] does not provide for a separate right to health. Rather, "health" is included in the right to an adequate standard of living.[25] The Charter of the United Nations (UN Charter), which has been in force since October 1945, already addresses health, but not in the specific shape of a human right: The States Parties transferred to the United Nations (UN) the very general task to promote solutions of health problems within the chapter on international economic and social co-operation (Article 55 lit. b).[26] Article 57 UN Charter provides for a specialized agency in the area of health and thus laid the foundation for the WHO which was established in 1948.[27] The preamble of the Constitution of the WHO declares the "enjoyment of the highest attainable standard of health" to be a fundamental right of every human being. Although the preamble is not binding in a legal sense,[28] it gained much po-

22 For an overview of the right to health in documents of regional human rights organizations: Toebes, *The Right to Health as a Human Right*, above Fn. 15, 62 et seqq.

23 Universal Declaration of Human Rights adopted by the United Nations General Assembly resolution on December 10, 1948 (A/RES/3/217 A).

24 Bernstorff, J von, "The Changing Fortunes of the Universal Declaration of Human Rights" (2008), 19 *EJIL*, 903 (913); Krennerich, "Menschenrecht auf Gesundheit", above Fn. 20, 57.

25 Article 25 (1) UDHR: Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

26 Further mentioning of "health" in Article 57 (Specialized Agencies) and Article 62 (Functions and Powers of the Economic and Social Council) of the UN-Charter.

27 WHO-Constitution adopted by the International Health Conference in 1946 and signed by the representatives of 61 States; entered into force on April 7, 1948.

28 Compare above Fn. 20.

litical attention and for the first time expressly acknowledged health as human right.[29] The mandate resulting from this proposition[30] raised high and unrealistic expectations. The WHO is guided primarily by a "policy oriented approach"[31], although it is also entrusted with a set of legal tools.[32] About 30 years after its foundation, in September 1978 the WHO organized a universal conference in Alma-Ata (then the capital of Kazakhstan) on primary health care which was attended by representatives of 134 states and 67 International Organizations. This widespread participation led to the historical meaning of the so-called Alma-Ata-Declaration, although it is not binding in a legal sense. The Declaration, which sees primary health care[33] as the key tool[34] for a *health for all*, reaffirms that health in the sense of a "complete physical, mental and social wellbeing" is a "fundamental human right". It is noteworthy, though, that the "highest possible level of health" is not directly mentioned as part of the human right to health as such, but as a "most important world-wide social goal". Primary health care is defined and outlined in seven points.[35] In addition to "promotive, preventive, curative and rehabilitative services" health care is also seen in the broad context of health education as well as safe food and water. The Declaration further

29 It is not known whether the drafters were aware of the legal claims going on with a "right to health", see Toebes, *The Right to Health as a Human Right*, above Fn. 15, 32.

30 Compare also Article 1 WHO-Constitution.

31 Riedel, "The Human Right to Health: Conceptual Foundations", above Fn. 8, 23.

32 For a short overview of the standard-setting instruments of the WHO compare Toebes, "International health law", above Fn. 1, 305 et seqq.; see also Gostin, "Global Health", above Fn. 1, 1733 et seq.

33 Compare for a description of primary health care also CESCR, *General Comment 14*, above Fn. 8, footnote 9: "primary health care typically deals with common and relatively minor illnesses and is provided by health professionals and/or generally trained doctors working within the community at relatively low cost".

34 Compare Poudel, "The Right to health", above Fn. 5, 219: "The Declaration of Alma-Ata had a significant role with respect to the development of a right to health. The Declaration developed the bases for implementing primary health care systems."

35 The concept of "primary health care" as stated in Alma-Ata has been criticized as "elusive" (for example Tobin, *Right to Health in International Law*, above Fn. 3, 264). Tobin also points to the fact that primary health care was a concept "in response to the ineffectiveness of the dominant Western model of medical or institutional based health care in developing countries". There is to-date no uniform definition of primary health care except for certain core principles (see, for example the WHO's *World Health Report*, 2003, 106-107, available at http://www.who.int/whr/2003/en/).

recognizes that the "people have a right and duty to participate individually and collectively in the planning and implementation of their health care". The latter assertion as well as other statements in the Declaration show that the right to health is conceived as going beyond an individual human right. After the Alma-Ata-Declaration, a series of global conferences on health promotion followed, the last having taken place in Shanghai (China) in November 2016.[36] All these conferences on health promotion ended with an official statement, the earliest being the well-known Ottawa-Charter (1986).

2 The Right to Health within the International Covenant on Economic, Social and Cultural Rights

Besides the system of the WHO, a major step of the development of the human right to health was its inclusion in the International Covenant on Economic, Social and Cultural Rights (ICESCR) in 1966.
Article 12 ICESCR reads as follows:

> "1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
> 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
> (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
> (b) The improvement of all aspects of environmental and industrial hygiene;
> (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
> (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."

Article 12 ICESCR acknowledges the "enjoyment of the highest attainable standard of physical and mental health" as a human right, followed by a non-exhaustive enumeration as to its specific content. The ICESCR does not define health as such,[37] but makes clear that both physical and mental health are comprised.[38] The provision encompasses an ambitious statement

---

36 For an overview see WHO, *Global Health Promotion Conferences*, available at http://www.who.int/healthpromotion/conferences/en/.

37 CESCR, *General Comment 14*, above Fn. 8, para. 4; Toebes, *The Right to Health as a Human Right*, above Fn. 15, 43, 47 et seq., 51.

38 Initiatives to stretch the right to health by definition to the "social wellbeing" or even "moral wellbeing" were dismissed during the drafting period of Article 12 ICESCR (Krennerich, "Menschenrecht auf Gesundheit", above Fn. 20, 60).

as to the scope of health, namely that it grants the people a right to the "highest attainable standard". Article 12 ICESCR is to be viewed in light of its context. Article 2 para. 1 ICESCR reads:

> "Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its *available resources*, with a view to achieving *progressively* the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures." (emphasis by author)

This clause tries to bridge between the ambitious aims of the single provisions of the Covenant and the insight that states are not economically developed and equipped in the same manner and therefore cannot provide for the same standards of social, economical and cultural rights. The clause is admitting that the aims of the treaty provisions, such as the "highest attainable" standard of health, cannot be an immediate binding obligation because *impossibilium nulla obligatio*. The inclusion of obligations that are more aspirational in nature demonstrates that, in international law, binding treaties can also display a mixed character as a policy-oriented approach and a legal basis for claims. Therefore, Article 2 para. 1 ICESCR is the essential link to uphold a legal character of the whole covenant. At the same time, this clause reveals that the lack of resources is not an argument in itself, but that a state needs to make efforts to strive for further progress ("progressively"). Thus it is widely assumed that states can have different obligations under the ICESCR.

In the tension between political aspirations and legally binding obligations, the Committee on Economic, Social and Cultural Rights (CESCR) has developed the concept of "minimum core obligations".[39] The Committee has specified these core obligations also with regard to the "right to the highest attainable standard of health" in its General Comment No. 14 dating from 2000.[40] Although the interpretations of the treaty provisions by the CESCR are not legally binding, the General Comments are treated as being authoritative.[41] They are not undisputed however, because the

---

39 CESCR, *General Comment No. 3 (The Nature of States Parties' Obligations)*, para. 10; *General Comment 14*, above Fn. 8, para. 43 et seq.

40 CESCR, *General Comment 14*, above Fn. 8, para. 43 et seqq. The core obligations are discussed below under IV 1.

41 See Nieada-Avshalom, L, "Some scepticism on the right to health: the case of the provision of medicines" (2015), 19 *The International Journal of Human Rights*, 527 (529), who recognizes that the CESCR comments are not binding and at the

CESCR is at times transgressing the path of interpretation and instead legislating.[42]

The CESCR describes the normative content of the right to health of Article 12 ICESCR as embracing freedoms and entitlements. "Freedoms" entail claims as to be free from (state) interference such as "the right to control one's health and body" and the right to be free from "non-consensual medical treatment and experimentation". The entitlements are, broadly speaking, focused on "the right to a system of health protection".[43] The Committee is further interpreting the right to health as

> "an inclusive right extending not only to […] health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, and adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information".[44]

The CESCR identifies the so-called "AAAQs", standing for "availability", "accessibility", "acceptability" and "quality",[45] which are interrelated and subject to the particular conditions in a State Party.[46] Thus, health care and other health-related elements (such as potable drinking water) have to be *available* in sufficient quantity. *Accessibility* is seen in four dimensions, namely (1) non-discriminatory accessibility (accessible also for vulnerable and marginalized groups), (2) physical accessibility ("health facilities […] must be within safe physical reach" for all persons), (3) economic accessibility (in the sense of "affordability"), and (4) accessibility of information (relating to health issues). With "acceptability" the CESCR relates to a respect for medical ethics and cultural backgrounds. The notion of "quality" means that services must be "scientifically and medically appropriate". Besides the idea of the AAAQs, the CESCR also uses the concept of the threefold obligations to "respect, protect and fulfil".[47] The obligation to *respect*

---

same time acknowledges that they are "authoritative interpretations"; Toebes, "International health law", above Fn. 1, 309.

42 Riedel, "Human Right to Health", above Fn. 9, 27.

43 CESCR, *General Comment 14*, above Fn. 8, para. 8.

44 Ibid., para. 11. This broad concept has been widely accepted, compare only Wilson, B, "Social Determinants of Health from a Rights-Based Approach" in Clapham, A & Robinson, M (eds.), *Realizing the Right to Health*, 2009, 60 et seqq.

45 The AAAQ´s are often quoted and further elaborated in the academic literature, see only Riedel, "Human Right to Health", above Fn. 9, 28 et seqq.

46 CESCR, *General Comment 14*, above Fn. 8, para. 12.

47 Ibid., para. 33. For further explanation see also Riedel, "Human Right to Health", above Fn. 9, 26 et seqq. and Krennerich, "Menschenrecht auf Gesundheit", above Fn. 20, 68 et seqq.

"requires states to refrain from interfering directly or indirectly with the enjoyment of the right to health".[48] The obligation to *protect* is of a horizontal dimension whereby the state has to protect the people (or individual) from possible harm brought about by third parties (like private insurance companies, private suppliers of medical equipment and medicines and health professionals). The states need to control their quality and make sure that these private actors do not "constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services".[49] The obligation to *fulfil* goes one step further in that the states need to adopt appropriate measures (especially legislative) in order to bring about the full realization of the right to health (for example "immunization programmes against the major infectious diseases"[50]). Also, states are obliged to "create, maintain and restore the health" for individuals or a group if they cannot "for reasons beyond their control" realize this themselves.[51]

Besides this, the CESCR clarifies that the "highest attainable standard" is a reference as well to the "individual's biological" as well as the "social-economic preconditions and a State's available resources".[52] With this finding, the CESCR aims at preventing the right to health from turning into a mere unrealistic utopia. Further, the Committee identifies obligations of immediate effect in order to avoid Article 12 ICESCR from becoming a mere political target.[53] Namely these are the duty to guarantee that the right to health is "exercised without discrimination" and the "obligation to take steps towards the full realization of article 12". These duties are, however, still considerably broad and flexible and thus are not providing enough clout to claim any rights on this basis. As mentioned already, the Committee has also defined more specific core obligations. Surprisingly, the CESCR did not expressly declare that these core obligations are those which are of immediate effect.

The right to health as established by Article 12 ICESCR has also been further interpreted by the UN Special Rapporteurs on the right to health.[54]

---

48 CESCR, *General Comment 14*, above Fn. 8, para. 33.
49 Ibid., para. 35.
50 Ibid., para. 36.
51 Ibid., para. 37.
52 Ibid., para. 9.
53 Ibid., para. 30.
54 The first Special Rapporteur was appointed by the Commission on Human Rights in April 2002. The mandate was later endorsed and extended by the Human Rights

In their reports, the UN Special Rapporteurs deal with certain specific aspects of the right to health. Recent topics have included unhealthy food and non-communicable diseases,[55] the right to health in conflict situations[56] and access to medicines.[57] The Reports also focus on certain groups such as migrant workers[58] and older persons.[59]

3 The Right to Health for Specific Groups and Marginalized Individuals

Human Rights Law has specifically focused on vulnerable groups or marginalized individuals in order to improve their situation.[60] In this context, health is addressed in specific conventions on women,[61] children,[62] migrant workers,[63] employees,[64] and disabled persons.[65] These specific groups and individuals have special needs which are considered in the respective international treaties and other soft law instruments. As poor health is very often related to a weak socioeconomic background of the respective people or

---

Council (last in October, 2013). For a detailed overview of the different mandates see http://bit.ly/2kTASyn.

55 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/HRC/26/31 of 2014.

56 A/68/297 of 2013.

57 A/HRC/23/42 of 2013; A/HRC/17/43 of 2011; A/65/255 of 2010; A/HRC/11/12 of 2009.

58 A/HRC/23/41 of 2013.

59 A/HRC/18/37 of 2011.

60 For an overview of the right to health with regard to special groups see for example Krennerich, "Menschenrecht auf Gesundheit", above Fn. 20, 61 et seqq.

61 Convention on the Elimination of All Forms of Discrimination against Women (adopted by General Assembly resolution on December 18, 1979, A/RES/34/180, entry into force September 3, 1981): Article 12 (see further Article 10 lit. h; Article 11 para. 1 lit. f; Article 14 para. 2 lit. b).

62 Convention on the Rights of the Child (adopted by General Assembly resolution on November 20, 1989, A/RES/44/25, entry into force September 2, 1990): Article 24 (see further Article 3 para. 3; Article 23 para. 3 and 4; Article 25; Article 32 para. 1).

63 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (adopted by General Assembly resolution on December 18, 1990, A/RES/45/158, entry into force July 1, 2003) Article 28 (see further Article 25 para. 1 lit. a; Article 43 para. 1 lit. e; Article 45 para. 1 lit. c; Article 70).

64 The ILO conventions contain numerous provisions related to health.

65 Convention on the Rights of Persons with Disabilities, Article 25.

individuals, it is of particular importance that international human rights law addresses health not only as a general matter, but also as a special need of these groups and persons who cannot in the same manner care for themselves or afford to have access to medical treatment.

III The Right-Holders of the Right to Health: Individual Right, Collective Right or Mere Standard?

1 The Different Dimensions

The right to health is ambiguous as to its structure and rights holders. It could possibly be perceived, as an individual right (either in the sense of a "liberty right" or a "social right"), as a collective (group) right[66] (if it is assumed that a group can be a right-holder) or, as a mere standard (as an "objective" obligation of the state) to promote public health. In other words, the right to health is not restricted to the individual's dimension, but also contains an obligation to promote public ("population") health which connotes either a collective (group) right or a mere "objective" obligation of the state without corresponding individual rights. In this contribution, "objective obligations" are meant to embrace all legal obligations, while individual rights are restricted to those obligations which endow the individual with a right (claim). Thus an "objective obligation without a corresponding individual right" is a "standard" which is to be followed by a state without giving the individual (or a "group") a right to legally claim it.

Historically, the public health approach preceded the notion of a right to health as individual right.[67] Under the manifold definitions and descriptions of public health, only one shall be quoted here, stemming from the American Public Health Association: "Public health is the practice of preventing disease and promoting good health within groups of people, from small communities to entire countries."[68] Public health is concerned with the population, the "people", "groups" and lastly "numbers" and not individual patients. It is a policy-oriented approach which deals with maintain-

66 As to the debated existence of group rights, see above Fn. 11.

67 Murphy, T, *Health and Human Rights*, 2013, 30.

68 American Public Health Association, *What is Public Health? Our Commitment to Safe, Healthy Communities*, available at https://www.apha.org/~/media/files/pdf/factsheets/whatisph.ashx.

ing the health of the people in a comprehensive and interdisciplinary perspective, also including the arrangement of socioeconomic and environmental conditions for the promotion and maintenance of health. If it comes to legal terms, the focus lies primarily on the "objective" obligation of the state (or other actors) to arrange for a setting which allows the maximum health for the whole population. The individual right to health, on the other hand, is starting from a "subjective" point of view. It considers what an individual person needs to become or stay healthy.

2 Approach of the CESCR and the UN Special Rapporteur on the Right to Health

In order to examine whether Article 12 ICESCR is seen primarily as an obligation to promote public health or as an individual human right, the interpretations of the CESCR and the UN Special Rapporteur on the Right to health are of high relevance. In its general comment, the CESCR starts with a clear human rights perspective:

> "Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity."[69]

On the other hand, the CESCR recalls on a number of occasions that the promotion of health is not confined to medical care, but embraces the "underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment".[70] This reflects a public health approach that is an integrative concept and also includes elements, such as a "healthy environment", which are in the first instance more a political strategy than an individual right. When the CESCR is elaborating on the "normative content" of Article 12 ICESCR,[71] it combines both concepts. The "freedoms" of the right to health are clearly of an individual nature. If we regard freedoms such as "to control one's health and body" or freedom from "non-consensual medical treatment and experimentation", those freedoms do not only entitle the individual, but also show that – for example with regard to particular research interests – the conflict of interests is resolved

69 CESCR, *General Comment 14*, above Fn. 8, para. 1.
70 Ibid., para. 4. See also para. 10, 11 and 36, 40.
71 Ibid., para. 7 et seqq.

in favor of the individual[72] (while "population health" would benefit best if many people took part in clinical trials, the individual only takes advantage of its participation if the chances for healing outweigh the possible damages). Turning to the entitlements, the CESCR states that these "include the right to a system of health protection".[73] A system of health protection is clearly not enforceable as such, only specific elements might be part of an individual's claim before a court. Therefore, the AAAQs (see above), which break down the general notion of a right to a proper health system, again display both the elements of individual and public health. The CESCR's reference to certain vulnerable groups (maternal and child health, healthy workplace, older persons, persons with disabilities, indigenous peoples, etc.) are primarily part of a public health approach in order to grant the particular group the same rights or even special attention as to their special needs. However, it can also be read as an obligation to provide legal rights for the individuals of these groups. In its section on the implementation at the national level, the CESCR seems to break down population health to individual claims when stating: "Any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels."[74] The Committee further explains that "States parties are bound by both the collective and individual dimensions of article 12".[75] According to the CESCR, Article 12 ICESCR obliges the State Parties to

> "give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realizing the right to health".[76]

This shows that some aspects of the right to health remain in the political sphere, while others shall be framed as (national) legal rights.

The reports of the UN Special Rapporteurs on the right to health also display both a reference to the individual right to health and a public health approach. In the first annual report, the UN Special Rapporteur saw his work being guided

---

72 Compare also Article 3 of the Universal Declaration on Bioethics and Human Rights (adopted by UNESCO's General Conference on October 19, 2005).
73 CESCR, *General Comment 14*, above Fn. 8, para. 8.
74 Ibid., para. 59.
75 Ibid., footnote 30.
76 Ibid., para. 36.

> "by the fundamental principle that international human rights law, including the right to health, should be consistently and coherently applied across all relevant national and international policy-making processes."[77]

Over the years, the Special Rapporteurs have focused on different "groups" rather than the individual (for example reports being on the right to health of adolescents[78] and early childhood[79]). Then again, in its recent report of 2014, the Special Rapporteur was dealing in detail with the "justifiability of the right to health"[80] and the "enforcement"[81] and thus brought the right to health into the legal realm of individual claims. Health is seen as a precondition for the "individual's ability to live with dignity".[82] The Special Rapporteur aims at strengthening the domestic justifiability of the right to health in its three dimensions (respect, protect, fulfil) in order to "fulfil the right to health of individuals".[83] Also the report on informed consent[84] is in the first place an expression of the individual's right to health. However, it is often not entirely clear whether the emphasis lies on the individual's right to health or a public health perspective.[85]

3 The Necessity to Differentiate Between the Dimensions

In many writings on the international right to health, both the individual right to health and the concept of public health are not differentiated. This is striking not only because public health is of a different nature than an individual right to health, but also because both can compete with each other. Very obviously this is the case when it comes to epidemics control.[86]

---

77 E/CN. 4/2003/58 (February 13, 2003), para. 8.
78 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/HRC/32/32 of 2016.
79 A 70/213 of 2015.
80 A/69/299 (August 11, 2014), para. 5 et seqq.
81 Ibid., para. 30 et seqq.
82 Ibid., para. 71; for a critical view see Tobin, *Right to Health in International Law*, above Fn. 3, 56.
83 A/69/299 (August 11, 2014), para. 72.
84 A/64/272 (August 10, 2009).
85 Compare only A/HRC/7/11 (January 31, 2008), para. 38: Health system should focus on the "well-being of individuals, communities and populations".
86 See also the International Health Regulations (IHR) which try to balance individual rights and a public right to health, compare Zidar, A, "WHO International Health Regulations and human rights" (2015), 19 *The International Journal of Human Rights*, 505.

From an individual's perspective, each person who is infected needs medical treatment, even if the person is terminally ill. From a public health perspective, the medical resources should be distributed in the way that saves the life of most. Certainly, individual rights can be limited due to the rights of others, but as a matter of principle, the structure of an individual right is all about the health of a person (and that the person is entitled to claim this right) while public health is all about the health of a population. Both concepts merge together in that the public right to health ultimately serves human beings. But while public health is all about numbers and groups and fair distribution of resources, the individual right to health involves granting a right to an individual person. Thus, if it comes to an individual right, a person ideally needs the possibility of recourse to a legal action if his right is violated. A public health approach can do without such individual legal action and becomes effective by diverse political and legal monitoring systems. If it comes to the fair distribution of limited resources, a public health strategy is most effective if based on a utilitarian ethic[87], while an individual's rights approach is effective if the individual can enforce its right to health irrespective of utilitarian arguments.

Katarina Tomaševski[88] has already addressed the issue in 1995, before the release of the CESCR's general comment on the right to health. Under the title "Balancing Public Health and Human Rights"[89] she shows how both concepts can clash. With examples such as "immunizations" which are only effective if at least 80 % of a particular population participate, she underpins her argument that public health necessities can infringe individual rights.

> "Many public health measures may deny individual rights and justify this by the need to protect society. With epidemics, the objective of public health measures is to identify and isolate the affected persons. Such persons lose their identity, privacy, dignity, their individuality, and become merely 'carriers' of a disease."[90]

Tomaševski also shows the limits of public health policies when they are at odds with individual rights. There has to be a balancing of both the individual and collective right to health whereby "limitations are legitimate

87 Compare Toebes, "Human rights and public health", above Fn. 3, 490 who argues that the ideas of the utilitarian philosopher Jeremy Bentham influenced the origins of public health in 19th century England.
88 Tomaševski, "Health Rights", above Fn. 19, 125 et seqq.
89 Ibid., 137 et seqq.
90 Ibid., 139.

only when required on public health grounds, and compatible with the general human rights principles".[91]

Brigit Toebes also reflects on a clash of public health and the individual right to health.[92] She sees this tension especially when it comes to "health security threats" in the fields of infectious diseases, biomedical research with human beings, use of bio-banks, (forced) vaccinations as well as testing of medicines. With regard to the outbreak of Ebola she points to the "huge dilemmas under human rights law" and requests a careful balancing of a public health and an individual rights approach. Restrictions of the right of the individual should be "proportionate, pursue a legitimate aim and […] taken solely for the interests of a democratic society".[93] According to *Toebes*, the right to health is in the first place a protection of individual health.[94] She states that "as a human right the right to health pertains to an individual rather than to a collective claim".[95] Therefore, she finds it problematic when the right to health is understood "as a norm that reflects the protection of 'public health'" as it would then amount to a "'collective' norm, protecting the health-related interests of a community or the population at large".[96] However, *Toebes* adds another dimension and also conceives the right to health as a "'bundle' of individual rights exercised by a collectivity".[97] In the latter function the right to health could potentially serve as a collective claim against actors who are a detriment to the health of the people (such as the tobacco industry or the polluting industry).

A rather critical view was put forward by *Laura Nieda-Avshalom*.[98] She examines the obligation of states to provide for medicines as part of the right to health under Article 12 ICESCR. As medicines can be costly and unaffordable, she asks how states should decide which medicine to provide and which legal, moral and political principles should guide the allocation

---

91 Ibid., 139.

92 Toebes, "Human rights and public health", above Fn. 3, 499; Toebes, "International health law", above Fn. 1, 311.

93 Toebes, "Human rights and public health", above Fn. 3, 500.

94 Toebes, "International health law", above Fn. 1, 308, 311.

95 Ibid., 311.

96 Ibid., 311.

97 Toebes, "Human rights and public health", above Fn. 3, 500; see also Toebes, "International health law", above Fn. 1, 311: "We could perceive the right as materially conferred on individual members of a group, but procedurally looked after by the collectivity. Hence this could potentially be overcome by perceiving the collective right to health as a bundle of individual rights."

98 Nieada-Avshalom, "Some skepticism", above Fn. 41, 527 et seqq.

and prioritization under the international right to health. Using the distribution of medicine as field of reference, *Nieda-Avshalom* argues that the right to health is still underdetermined and that the solution of allocation problems "entails legal, moral and political flaws".[99] She shows that the current interpretation of Article 12 ICESCR as provided by the CESCR is in line with a utilitarian view because it favors a distribution of resources which serves most people to the detriment of severely ill people with rare diseases who need expensive drugs. *Nieda-Avshalom* wonders why a rare and expensive illness would not fall under the right to health and asks: "Is this even a right?"[100] She stipulates that Article 12 ICESCR is primarily following a public health approach, pointing to the four dimensions of Article 12 (a-d):

> "Three out of four dimensions referred to by the ICESCR can be seen as public health interventions, namely, child health (article 12 (2)(a)), environmental and industrial hygiene (article 12 (2)(b)), and the management of epidemic, pandemic, occupational and other diseases (article 12 (2)(c))".[101]

She further argues that primary health care should not be viewed as public health policy, but as "*a* particular element of health assistance to be implemented in the context of health systems."[102] She concludes that "the ICESCR indicates several broad dimensions but overall it seems to have a penchant for a public health and primary health care that would improve the aggregate status of the population rather than specific individual curative needs."[103]

IV A Reflection on the Content of the Right to Health

So far we have seen that the normative content and structure of the right to health is still vague. This is due to a number of reasons, namely the fact that it is conceived in a broad manner as a "transversal right" embracing a set of different rights, and thus goes far beyond the right to medical treatment. Also, the ambiguous structure of an individual human right on the one hand and the obligation to promote public health on the other hand leads to confusion, especially when these concepts are in conflict with each other. Public health policies were pursued long before a "human right to health" was

99 Ibid., 527.
100 Ibid., 540.
101 Ibid., 531.
102 Ibid., 531.
103 Ibid., 539.

acknowledged. And even though a human right implies in the first instance an individual right, the human right to health has also been largely understood as public health strategy. In a way, two separate systems have become intertwined. But they can also be viewed as complementary because public health strategies, especially the control of contagious diseases, are having immediate effects on the individual's health. Therefore, it can make sense to see the right to health as an "umbrella" for both the individual's right to health and public health obligations.

1 Current Approaches

The problems associated with the wide scope of the right to health are obvious. *Heiner Bielefeldt*[104] differentiates between the state's responsibility of gradual development of the right to health, which includes health strategies, health planning, research funding, medical training, public health education as well as further infrastructure measures on the one hand, and the personal legal entitlement as to the right to health on the other hand. According to him, the first set of responsibilities is of a long-term character (successive development), while the right to health in terms of a legal entitlement should be effective immediately. He also refers to the idea of core obligations as justifiable rights.

The idea of core obligations[105] as a key concept of the CESCR to narrow the scope of the right to health in order to enlarge its effectiveness, has been largely accepted in the literature.[106] In its General Comment No. 14 on the Right to Health, the Committee defines the scope of core obligations as comprising non-discriminatory access to health facilities and equitable distribution of health facilities, access to minimum essential and safe food and water, access to basic shelter and sanitation, and essential drugs. The CESCR recognizes that State Parties have the obligation "to adopt and implement a national public health strategy and plan of action, on the basis of

104 Bielefeldt, "Menschenrechtsansatz", above Fn. 5, 48.

105 See above Fn. 39.

106 A. Müller, "Die Konkretisierung von Kernbereichen des Menschenrechts auf Gesundheit" in Frewer, A & Bielefeldt, H (eds.), *Das Menschenrecht auf Gesundheit*, 2016, 125 et seqq.; Riedel, "Human Right to Health", above Fn. 9, 32; Gostin, "Global Health", above Fn. 1, 1736.

epidemiological evidence, addressing the health concerns of the whole population".[107] Under the core obligations, the Committee identifies "obligations of comparable priority",[108] namely reproductive, maternal and child health care. It obliges states to provide "immunization against the major infectious diseases occurring in the community" as well as supplementary measures of epidemics control.[109] It also includes an obligation to provide for access to health education and to enable adequate training for health personnel. The designation of these core obligations is meant to help the states to prioritize within their duties of the right to health. At the same time, the idea is to support and enable the establishment of legal proceedings before national and international courts or quasi-judicial bodies.[110] Although the whole concept of core obligations is only persuasive if states cannot argue that they have insufficient resources to observe and fulfill these obligations,[111] it is nevertheless debated whether the core obligations form part of the body of duties which only needs to be progressively realized. The CESCR is not entirely clear on this point. In General Comment No. 14, it claims that "a state party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations".[112] The CESCR rejects the objection of *impossibilium nulla obligatio* by the argument that a state has the obligation to seek international help if the resources for the core obligations are missing.[113] This, however, presupposes that there is such an extraterritorial obligation of states, be it individually or collectively or via the support of the WHO or other international actors – a highly contested field.[114] Then again the practice of the CESCR within its concluding observations regarding the State reports under the ICESCR (Article 16 et seq.) is not clear in the same manner. Only very rarely did the CESCR criticize a state for its failure to provide access to basic medical care although this

107 CESCR, *General Comment 14*, above Fn. 8, para. 43.
108 CESCR, *General Comment 14*, above Fn. 8, para. 44.
109 CESCR, *General Comment 14*, above Fn. 8, para. 44.
110 Müller, "Die Konkretisierung von Kernbereichen", above Fn. 106, 130.
111 See only Riedel, *Right to Health*, above Fn. 6, para. 41.
112 CESCR, *General Comment 14*, above Fn. 8, para. 47-48.
113 Ibid., para. 45.
114 See the contribution of *Elif Askin*, "Extraterritorial Human Rights Obligations of States in the Event of Disease Outbreaks" in this volume; Müller, "Die Konkretisierung von Kernbereichen", above Fn. 106, 140 et seq., 150; Tobin, *Right to Health in International Law*, above Fn. 3, 369, visualizes international cooperation, at most, as a "soft" obligation.

obligation forms part of the core obligations.[115] This leads to an ongoing debate as to whether the core obligations are to be defined on a universal level or on a national level.[116] Writers in favor of a nationally defined core content[117] argue that it is delusive to assume that all states could provide the same core content for their inhabitants. While poor countries would not be able to reach the threshold, rich countries would become complacent and remain below their potential. Also, any universally defined core content would be too abstract and not flexible enough. Other writers oppose this view[118] and argue that any nationally defined core content would be about the same as the progressive realization because the latter depends on the capacity of the particular state. Thus the idea of a "core content" would lose its function. Furthermore, the core content embraces only very basic rights which should be realized by all states. As both views have deficits and approvable aspects, *Amrei Müller* combines elements of both.[119] According to her proposal, the universal core obligations which are necessarily broad and less concrete, need to be complemented by a further national definition and commitment. The universal core obligations would have to include access to medical care and could be formulated after utilitarian values. The national core obligations should focus for example on infectious diseases which are predominant in the respective country. With her approach, *Müller* aims at

---

115 Müller, "Die Konkretisierung von Kernbereichen", above Fn. 106, 133.

116 For an extensive overview of this debate compare Müller, ibid., 134 et seqq.

117 Craven, M, *The International Covenant on Economic, Social and Cultural Rights*, 1995, 141 et seq., 152 with further references (Craven speaks of lack of clarity "whether these standards are international or State-specific"; he sees the "current practice of the Committee" to suggest "that in the short term at least, State-specific minima are the only viable options"; however, he also sees evidence "that the Committee intends to establish international standards in future"); Scott, C & Alston, P, "Adjudicating Constitutional Priorities in a Transnational Context" (2000), 16 *South African Journal of Human Rights*, 206 (250).

118 Engbruch, K, *Das Menschenrecht auf einen angemessenen Lebensstandard*, 2007, 137 et seq.; Russel, S, "Minimum State Obligations" in Brand, D & Russell, S (eds.), *Exploring the Core Content of Socio-Economic Rights: South African and International Perspectives*, 2002, 11 (15); Economic and Social Council, ICESCR, *The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights*, E/C.12/2000/13, para. 25; Bilchitz, D, *Poverty and Fundamental Rights*, 2007, 178 et seqq.; Ssenyonjo, M, *Economic, Social and Cultural Rights in International Law*, 2009, 66.

119 Müller, "Die Konkretisierung von Kernbereichen", above Fn. 106, 139 et seqq.; Her thesis is referring to the works of Bilchitz, *Poverty and Fundamental Rights*, above Fn. 118, 220-225.

defining "effective" core obligations whereby effectiveness is meant in the sense of the greatest possible range of rights which are as precise as possible. It seems that the view of *Müller* finds some support in recent general comments of the CESCR in which the Committee asked states to provide a benchmarking of indicators. However, the states have not shown much cooperation here.[120] *Müller*'s proposal would not only lead to different state obligations under the same treaty provision (which is already true within the conception of "progressive realization"), but would make these different obligations more obvious and the state's compliance verifiable. It is not very likely that states are willing to engage in this approach when their responsiveness to their own standards will be part of the states reporting procedure under the ICESCR.

2 Further Differentiated Approach

In the following, a further development of the current approaches shall be put forward. It combines the findings that the right to health according to Article 12 ICESCR has a subjective[121] (in the sense of an individual) rights component as well as an objective (in the sense of a public health) component (see above III.1) and furthermore differentiates between the different contents of the right to health.[122] International human rights law lacks clarity as to the question whether human rights necessarily imply subjective (= individual) international rights (which grant a claim) or whether they also include human rights which are framed as "standards" to be followed by the states ("objective" obligation of states) for the benefit and essential needs of human beings.[123] It is noted that "in its most basic form, a right is an

120 For more details see Riedel, "The Human Right to Health: Conceptual Foundations", above Fn. 8, 36.

121 Compare Peters, A, *Jenseits der Menschenrechte*, 2014, 469 et seqq.

122 The "group right" to health is not considered separately because it can partly be counted to the individual rights (individual having a right as part of the group). The genuine "group" as right-holder is underdeveloped in international law and it is argued here that in so far as there is no individual right, there is only an objective obligation of the states to grant certain rights to groups.

123 Compare Peters, *Menschenrechte*, above Fn. 121, 469 et seqq. She develops her position of the "subjective international law" as a legal position of human beings which is not merely derivative of the rights of states.

entitlement of X that gives rise to duties or obligations that can be claimed against Y".[124] Human rights law does not meet this threshold in different regards. The whole concept of a human "right" is under a broad discussion and the philosophical and legal reasoning behind the idea of human rights is facing many flaws.[125] The deficiencies of the theories behind are often superseded by the political will to promote the moral good.[126] *John Tobin* warns that an overly harsh critique of the deficient theories supporting human rights could eventually become "the enemy of the good".[127] He further argues for human rights "beyond individualism".[128] The right to health shall not simply "benefit individuals" but would also be "intended to bolster the interests of the broader community".[129] Under a social interest theory of rights "the justification in elevating an interest such as health to the status of a human right rests in the deliberative and collaborative process by which states (subject to lobbying and advocacy from civil society and institutional bodies) identify and elevate a particular interest to the status of a human right".[130]

Here it is argued that the international right to health has two dimensions, being of an individual (subjective) nature, as well as an objective nature (standard). One could argue that only the individual right to health is a true "human right" as a mere legal standard has no individualized, entitled party and that human rights are, by definition, rights of individuals.[131] However, the legal obligations acknowledged by states for the sake of serving basic needs of human beings, which ultimately go back to an understanding of a moral obligation towards human beings can also form part of the inter-

---

Compare also Beitz, C, *The Idea of Human Rights*, 2009, 137 (human rights as "urgent individual interests").

124 Tobin, *Right to Health in International Law*, above Fn. 3, 50.

125 Compare Bisaz, *The Concept of Group Rights*, above Fn. 11, 12 et seqq.

126 Compare Tobin, *Right to Health in International Law*, above Fn. 3, 50 et seqq.

127 Ibid., 53.

128 Ibid., 57 et seqq.

129 Ibid., 58.

130 Ibid., 59.

131 Riedel, *Right to Health*, above Fn. 6, para. 30 seems to require an individual right ("While policy programmes and practical guidelines play an essential role in the promotion of health care and protection for all, it is just as important that every human being is able to rely on a legal foundation which provides protection against intrusions upon one's personal health, and at the same time can serve as a tool to remind governments of their duties.").

national human rights body, as the concept of human social rights in international law is not exclusively linked to individual claims and recourse to legal action. Due to their different nature, the concept of human rights in international law and national law is not congruent. This view is strengthened by the finding that the human right to health first developed as an obligation of states to promote "public health"[132] and that – as shown above – even the CESCR is seeing public health as part of the human right to health. Therefore, the thesis put forward here aims at combining both aspects within the right to health, but at the same time differentiating them.

a Individual Right to Health

The first category is looking at the right to health from an individual's perspective and asking how it can become more effective for the single person. It is maintained that the individual's right to health should not be an "umbrella right" including all determinants for health, but rather focus more on a medical understanding of health. A multitude of factors can have a negative impact on a person's health – if all remedies are included in the individual's right to health, it would be more a "field of rights" and lose its power as a specific human right which can be claimed in a concrete situation. It seems to be persuasive to make the single human right more effective by being as precise as possible, as there is no need to cover "all with one" human right or to see a competitiveness between human rights.[133]

The right to "respect" health is clearly part of the individual right to health. The state must not infringe on a person's health. Also, the obligation of a state to protect a person's health from being hurt by third parties is part of the individual's right to health if there is a direct link (such as the duty to protect the individual from treatment without consent of the patient). With regard to the right to fulfill, the right to health should be understood to be basically a right to medical health care. Every person should have affordable access to basic medical care, including essential medicines.[134] This entails

---

132 Compare for a short historical overview Toebes, *The Right to Health as a Human Right*, above Fn. 15, 7 et seqq.

133 Some writers consider "health and human rights" as a new section of human rights law, compare Toebes, "International health law", above Fn. 1, 312.

134 As to the access to medicines, compare Marks, S P, "Access to Essential Medicines as a Component of the Right to Health" in Clapham, A & Robinson, M (eds.), *Realizing the Right to Health*, 2009, 80 et seqq.

that the state must provide for a health system which is available, accessible, acceptable and of proper quality (the so-called "AAAQs").[135] It does by no means imply that the state has to grant health care at no cost, but the state must establish a system (be it public or private) where it would be principally possible for everybody to participate. The WHO usually uses the classification of primary, secondary and tertiary health care whereby these three divisions display a different stage of specialization in health care.[136] Today the WHO is referring to "primary care" as a day-to-day health service. At least the access to basic medical care is a core obligation of the state. The boundary of self-responsibility and state's responsibility is fluent and to be decided in the particular country. The right to medical treatment should be guaranteed by each state including the possibility to take legal action. The quality of medical care should be as high as possible. As resources are always limited, the question of allocation needs to be decided by each state,[137] whereby the state needs to argue that it fulfilled its duty to take up measures to the maximum of its available resources (Article 2 para. 1 ICESCR).

b Obligation to Promote Public Health

The second category is looking at the right to health from the population's perspective. In fact, the right to health in international law is to a wide extent described to embrace those elements which usually go along with a public health approach. The focus lies on the objective obligation of states and possible other actors to promote public health. Looking at preventive measures in a narrower and broader sense, core obligations exist specifically with regard to infectious diseases. The control of infectious diseases is one of the basic ideas of public health.[138] The state bears the core duty to

135 For an elaboration on the right to health approach and health systems see Hunt & Backmann, "Health Systems and the Right", above Fn. 2, 40 et seqq.

136 For an overview Toebes, *The Right to Health as a Human Right*, above Fn. 15, 247. CESCR, *General Comment 14*, above Fn. 8, footnote 9.

137 Hunt & Backmann, "Health Systems and the Right", above Fn. 2, 49 argue that human rights have no "answer" to allocation questions, but "require that the questions be decided by way of a fair, transparent, participatory process, taking into account explicit criteria, such as the well-being of those living in poverty, and not just the claims of powerful interest groups". Compare also Weilert, A K & Pfitzner, J, "Konkurrenz im Gesundheitssystem" in Kirchhoff, T (ed.), *Konkurrenz. Historische, strukturelle und normative Perspektiven*, 2015, 313-340.

138 Fidler, D, *International Law and Public Health*, 2000, 3.

provide vaccination against diseases that occur regularly in a specific country. The states also need to ensure that the basic underlying determinants of health are met (such as clean water and safe food[139]). Those "preconditions" for health can be manifold, from obviously health-related conditions like access to clean water to broadly economic and social conditions. In order to avoid "public health" from becoming another term for socioeconomic policy, the underlying determinants for health should be closely connected to the condition of health. Furthermore, public health should not fully integrate all other health-related rights, but be defined as a separate field with overlapping edges.[140] Public health also includes access to basic health education and has a special focus on vulnerable groups (for example children, mothers, elderly people, and socially disadvantaged people). Main areas of the obligation to promote public health are the battle against infectious diseases, social medicine and the prevention of health threats including respective health research.

Within the endeavor to promote public health, the WHO plays a prominent role. In the founding document, the WHO's Constitution, the states transferred to it the task to enable and promote the highest possible level of health for all "peoples" (compare Article 1 WHO Constitution). It is noteworthy that the WHO's Constitution does not speak of "human beings", but in fact of "peoples". This goes along with the connotation of "public health" rather than an individual right to health. The term "human being" is only used once, namely in the preamble of the WHO Constitution where health is said to be a fundamental human right. It is significant that the operative part of the Constitution is not repeating health as a human right[141] and that Article 1 WHO Constitution, which sets out the objective of the WHO, speaks of the "attainment by all *peoples* of the highest possible level of health".[142]

---

139 Elements listed by Toebes, *The Right to Health as a Human Right*, above Fn. 15, 246.

140 Compare also Toebes, *The Right to Health as a Human Right*, above Fn. 15, 259 et seqq. and 272 who proposes a boundary between the right to health and other health-related rights such as life, physical integrity, privacy, education and information as well as housing, food and work. See also Giorgi, M, *The Human Right to Equal Access to Health Care*, 2012, 18 et seq.

141 Compare Hestermeyer, *Human Rights and the WTO*, above Fn. 2120, 114.

142 Compare also Murphy, *Health and Human Rights*, above Fn. 67, 28 (referring to the dispute whether the WHO's constitution is focusing on the "right to health of individuals" or rather the "security and well-being of states").

Also, the functions of the WHO as displayed in Article 2 WHO Constitution, clearly show the public health character (for example focus on epidemics control, nutrition, sanitation, environmental hygiene, and to promote health research). As public health has an international dimension (it becomes striking when it comes to epidemics control), the acknowledgement of a right to health automatically demands to provide for international structures. Besides the WHO there are many other actors, often of a private nature,[143] who promote health in the realm of "public health". Within the field of IHG, the relationships, obligations, and questions of authority of the different actors need to be further examined.[144]

c Enforcement Structures

The right to health, both in the sense of an individual right and in the meaning of an obligation to promote public health, needs enforcement structures in order to intensify its effectiveness, as well at the international as the national level. *Eibe Riedel* identifies five main types of accountability mechanisms, namely judicial, quasi-judicial, administrative, political and social.[145] Enforcement structures do not presuppose that the right to health is framed as an individual right. The review mechanism of the ICESCR via the assessment of States Parties' reports is independent of any individual claim and also works as a monitoring system towards the obligation of the states to promote public health. The Optional Protocol to the ICESCR (in force since May 5, 2013),[146] however, is building on the infringement of a person's right or a group right (Article 2 of the Optional Protocol). The international monitoring systems need to be accompanied by national enforcement structures.[147] The implementation of the right to health by the

143 See the contribution of *Mateja Steinbrück Platise*, "The Changing Structure of Global Health Governance" in this volume.

144 Compare also Toebes, "International health law", above Fn. 1, 321 et seqq.

145 Riedel, "Human Right to Health", above Fn. 9, 32 et seqq.; Riedel, "The Human Right to Health: Conceptual Foundations", above Fn. 8, 33.

146 Adopted by the United Nations General Assembly resolution on December 10, 2008 (A/RES/63/117).

147 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/69/299 (August 11, 2014), para. 30 et seqq.; Flood, C & Gross, A, *The Right to Health at the Public/Private Divide. A Global Comparative Study*, 2014, provides insight into the enforcement structures of different countries.

particular states is so far not sufficiently monitored and enforced at the international level.

V Conclusion

The human right to health is a highly complex right. Already the definition of health is anything but obvious. If health is perceived not merely as the absence of disease, but as "a state of complete physical, mental and social well-being", the right to health loses its sharpness in the legal context. The main legal source of the international right to health is to be found in Article 12 ICESCR which was here referred to as main source for all further considerations. The structure of the right to health faces challenges in different dimensions: First, the right to health combines aspects from all three generations of human rights; second, the right to health often serves as an umbrella right and loses its specificity as virtually everything can have an impact on a person's health; and third, the right to health is a hybrid right combining elements of an individual's health approach and a public (in the sense of population's) health approach. In this contribution it is argued that as an individual human right, the right to health should be perceived in a narrower sense and be more closely linked to the right to medical treatment. As an obligation to promote public health, the human right to health can be seen in a broader context, embracing also the underlying determinants of health and therefore focusing more on the preventive dimension. The battle against epidemics falls into the public health approach. In the latter sense, its effectiveness should not be measured in terms of the possibility of individual legal actions, but seen more as a policy strategy, embracing national and international actors who need to be coordinated in terms of International Health Governance.