

NORMATIVE EXPANSION OF THE RIGHT TO HEALTH AND THE PROLIFERATION OF HUMAN RIGHTS

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INTRODUCTION: THE PROLIFERATION OF HEALTH RIGHTS

The proliferation of human rights raises both philosophical and practical questions. Philosophically, when and under what limits is it appropriate to consider a normative proposition a human right? Practically, what formulation of human rights will guide individuals in a position to bring about change to mobilize resources in ways that will achieve the goals defined by the human right? Those working in the field of human rights tend to favor expanding the normative content of human rights to cover as much as possible to ensure human dignity.¹ A preliminary question is, therefore, whether more is better when it comes to enumerating human rights.

The push for the proliferation of human rights has had its detractors, going back at least to the nineteenth century, when Jeremy Bentham famously denounced “natural and imprescriptible rights” contained in the French Declaration of the Rights of Man and the Citizen as “rhetorical nonsense—nonsense upon stilts.”² As if that was not enough, Bentham also referred to the formulation of these rights as “mischievous nonsense,” “dangerous nonsense,” “miserable nonsense,” “rueful nonsense,” and even referred to the use of “terrorist language” in the Decla-

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1. See, e.g., THE INTERNATIONAL STRUGGLE FOR NEW HUMAN RIGHTS (Clifford Bob ed., 2009).

2. JEREMY BENTHAM, *Anarchical Fallacies; Being an Examination of the Declarations of Rights Issued During the French Revolution*, in 2 THE WORKS OF JEREMY BENTHAM 496, 500 (1962) (1843) [hereinafter BENTHAM].

ration.³ A more recent commentator denounced today's so-called "human rights inflation": "[W]e have a surplus of human rights—and they're all claimed to be equally important and indivisible. Human rights are going nowhere. They've lost their value."⁴ Political scientist Francis Fukuyama similarly expressed his frustration with the proliferation of rights:

Over the past generation, the rights industry has grown faster than an Internet IPO in the late 1990s. In addition to animal, women's and children's rights, there are gay rights, the rights of the disabled and handicapped, indigenous people's rights, the right to life, the right to die, the rights of the accused, victims' rights, as well as the famous right to periodic vacations Given this monumental confusion, why do we not . . . abandon talk of rights altogether?⁵

This Article explores the alleged proliferation of human rights through the example of the expansion of the right to health. It begins with a clarification of the current generally-recognized normative content of the right to health, and continues with a discussion of the new rights that have been proposed either as derivative from the right to health or as separate human rights complementary to it. In conclusion, it proposes a cautionary approach to proclaiming "new" human rights while favoring much of the normative expansion of the right to health.

A. The Right-to-Health Rejectionists

Many public health practitioners and medical doctors, being committed to the alleviation of human suffering, tend to assume, first, that any positive health attribute is a human right and, second, that the more such public health goods covered by human rights, the better.⁶ Some are not

3. See *id.* at 500–01. But see, e.g., Hugo Adam Bedau, "Anarchical Fallacies:" *Bentham's Attack on Human Rights*, 22 HUMAN RTS. Q. 261, 265 (2000) (explaining that what Bentham objects to in the Declaration are not really fallacies, since the Declaration is a manifesto of aspirations rather than arguments having the defects of fallacies).

4. Pedro Pizano, *The Human Rights that Dictators Love: Does the Concept of "Human Rights" Still have Meaning in a World Where Everything Qualifies?*, FOREIGN POLICY (Feb. 26, 2014), <http://foreignpolicy.com/2014/02/26/the-human-rights-that-dictators-love/> [https://perma.cc/FGC6-CEPC].

5. Francis Fukuyama, *Natural Rights and Human History*, 64 NAT'L INT. 19, 20–21 (Summer 2001).

6. Jonathan Mann, former World Health Organization (WHO) official and first François-Xavier Bagnoud Professor of Health and Human Rights at Harvard, famously wrote:

Modern human rights, precisely because they were initially developed entirely outside the health domain and seek to articulate the societal preconditions for human well-being, seem a far more useful framework, vocabulary, and form of guidance for public health efforts to analyze and respond directly to the societal determinants of health than any inherited from the biomedical or public health traditions.

Jonathan M. Mann, *Medicine and Public Health, Ethics, and Human Rights*, 27 HASTINGS CTR. REP. 9 (1997); see also David C. Thomasma, *Evolving Bioethics and International Human Rights*, in AUTONOMY AND HUMAN RIGHTS IN HEALTH CARE: AN INTERNATIONAL PERSPECTIVE

only vehemently opposed to the expansion of health-related human rights, however, but also to the right to health itself, as reflected in the reactions to the 1999 draft of the Tavistock Group's "Shared Ethical Principles for Everybody in Health Care."⁷ Principle One of that document stated that "Health care is a human right."⁸ In response, one neurosurgeon called the proposition, "[N]ot only wrong headed, it is unhelpful. Mature debate on the rationing and sharing of limited resources can hardly take place when citizens start from the premise that health care is their right, like a fair trial or the right to vote."⁹ Another commentator criticized the "manifesto" as "meaningless and devastating."¹⁰

Representing a legal perspective, lawyer and former Colorado Governor Richard Lamm warned in an American Bar Association publication, "It is problematic to consider health care as a 'right.' If everything is a right arguably, nothing is a right. We can easily dilute the important meaning of this word by claiming idealistically that all good things are 'rights.'"¹¹ U.S. lawyers occasionally equate international human rights with entitlements as understood in U.S. law,¹² but positive human rights are understood in international human rights law not as

11–24 (David N. Weisstub & Guillermo Diaz Pintos eds., 2008) (similarly arguing for applying human rights to the health domain).

7. See Richard Smith, Howard Hiatt, & Donald Berwick, *Shared Ethical Principles For Everybody In Health Care: A Working Draft from the Tavistock Group*, 318 *BMJ* 205, 248–51 (1999) [hereinafter Smith, *Shared Ethical Principles*]. The Group is named after the London location where the fifteen authors, mainly health professionals, met.

8. See *id.* at 250. The formulation of principle 1 reflects the composition of the Group, which was composed mainly of health practitioners and ethicists without much human rights expertise, except for Amartya Sen. It focuses on health care and does not draw on any provision of international human rights law.

9. Philip Barlow, *Health Care Is Not A Human Right*, 319 *BMJ* 269, 321 (1999).

10. Imre J.P. Loeffler, 'Health Care Is Not A Human Right' Is A Meaningless and Devastating Manifesto, 318 *BMJ* 1709, 1766 (1999).

11. Richard D. Lamm, *The Case Against Making Healthcare a "Right,"* 25 *HUMAN RTS.* 8, 9 (Fall 1998).

12. For example, the U.S. delegation stated to the Commission on Human Rights, "the realization of economic, social and cultural rights is progressive and aspirational. We do not view them as entitlements that require correlated legal duties and obligations." U.S. Government, Statement at the U.N. Commission on Human Rights, 59th Sess., Comment on the Working Group on the Right to Development (Feb. 10, 2003) (transcript on file with the author); see also, Curtis A. Bradley & Jack L. Goldsmith, *Treaties, Human Rights, and Conditional Consent*, 149 *U. PA. L. REV.* 399, 363 (2000) (pointing out that, compared to other countries, in the United States there is a "significantly different political culture (especially in its attitude towards international entanglements) and domestic human rights tradition" and that the U.S. agreement to general human rights norms does not mean "that human rights progress in the United States is best achieved by delegating the responsibility for determining the appropriate content of human rights to bodies outside the United States"). The argument that "entitlements ... lead to more and more interference with individual freedom" is found in Steven Yates, *Rights Versus Entitlements: A Government Which Knows Its Place Will Shun Entitlements*, FOUNDATION FOR ECONOMIC EDUCATION (Sept. 1, 1994), <https://fee.org/articles/rights-versus-entitlements/> [<https://perma.cc/UD4R-3BFR>].

funded entitlements but as essential obligations to take progressive steps to maximize its available resources to achieve economic, social, and cultural rights, as explained in the next Part.¹³

B. The Normative Framework

As a matter of international law, objections like Lamm's are moot since States Parties to international treaties, which posit the human right to health (including the right to healthcare), are legally bound by their treaty obligations, including at least five United Nations treaties¹⁴ and at least four regional treaties.¹⁵ The legal obligation States Parties undertake is "to take steps, individually and through international assistance and co-operation . . . to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant . . ." and "to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind."¹⁶ Thus, there is nothing novel about the core right to health as a matter of law; it is a long-established right in national constitutions and statutes,¹⁷ as well as in international treaties and state practice.¹⁸

The "steps" States Parties are expected to take to achieve the right to

13. See Part I.B.

14. The right to health is included in the following UN Treaties: *see, e.g.*, Convention on the Rights of Persons with Disabilities art. 25, U.N. Doc. A/61/49, 2515 U.N.T.S. 3, (Dec. 13, 2006); United Nations Convention on the Rights of the Child (CRC) art. 24, Nov. 20, 1989, 1577 U.N.T.S. 3; Convention on the Elimination of All Forms of Discrimination Against Women, art. 11.1(f), Dec. 21, 1965, U.N. Doc. A/34/46, 1249 U.N.T.S. 13; 19 I.L.M. 33 [hereinafter CEDAW]; International Covenant on Economic, Social and Cultural Rights (ICESCR) art. 12.1, Dec. 16, 1966, 993 U.N.T.S. 3 [hereinafter ICESCR]; The International Convention on the Elimination of All Forms of Racial Discrimination of 1965 (CERD) art. 5(e)(iv), Mar. 7, 1966, 660 U.N.T.S. 195. For further assessment on these provisions, *see generally* Stephen P. Marks, *Emergence and Scope of the Right to Health*, in *ADVANCING THE HUMAN RIGHT TO HEALTH* 8 (José M. Zuniga, Stephen P. Marks & Lawrence O. Gostin eds., 2013); Eibe Riedel, *The Human Right to Health: Conceptual Foundations*, in *REALIZING THE RIGHT TO HEALTH* 24 (Andrew Clapham, Mary Robinson, Claire Mahon & Scott Jerbi eds., 2009); JOHN TOBIN, *THE RIGHT TO HEALTH IN INTERNATIONAL LAW* (2012).

15. *See e.g.*, European Social Charter art. 11, Oct. 18, 1961, E.T.S. No. 163 (as revised in 1996); Organization of African Unity (OAU), The African Charter on Human and Peoples' Rights art. 16, Jun. 27, 1981; OAU, The African Charter on the Rights and Welfare of the Child art. 14, 1990; Org. of Am. States (OAS), Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights art. 10, Nov. 17, 1988; League of Arab States, Arab Charter on Human Rights art. 39, May 22, 2004.

16. *See* ICESCR, *supra* note 14, art. 2. Notably, the United States signed onto the ICESCR in 1977 but has not ratified it.

17. On national constitutions, *see* Eleanor D. Kinney & Brian Alexander Clark, *Provisions for Health and Health Care in the Constitutions of the Countries of the World*, 37 *CORNELL INT'L L. J.* 283 (2004).

18. On international treaties and state practice, *see* *ADVANCING THE HUMAN RIGHT TO HEALTH* 3–20 (José M. Zuniga, Stephen P. Marks, & Lawrence O. Gostin eds., 2013).

health are, however, a matter of interpretation.¹⁹ Most of the normative expansion discussed in this Article emerges from that interpretative process—the non-binding authoritative process of law-clarification²⁰—the results of which are sometimes confused with the proclamation of “new” rights.²¹ Sometimes—but rarely—a solid case can be made for a “new” right in accordance with preconditions to be discussed.²²

In legal scholar Dinah Shelton’s work on relative normativity, she notes that “non-binding instruments have an essential and growing role in international relations and in the development of international law.”²³ She identifies one such category of non-binding instruments as those “adopted by States Parties to ‘authoritatively interpret’ broad and undefined treaty obligations,”²⁴ including the General Comments adopted by human rights treaty bodies.²⁵ Shelton concludes: “The lack of a binding form may reduce the options for enforcement in the short term (i.e., no litigation), but this does not deny that there can exist sincere and deeply-held expectations of compliance with the norms contained in the non-binding form.”²⁶

What legitimate non-binding instruments have enriched the right to health, and when do efforts to expand this right go too far? To answer this question, this Article first examines how the core definition of the right to health has expanded through formal U.N. interpretative processes and proposals relating to “new” or “derivative” rights, before concluding with a proposal on bounding the right to health so as to avoid unbridled proliferation, while accepting reasonable normative expansion.

I. THE CORE DEFINITION AND INTERPRETATION OF THE RIGHT TO HEALTH

The right to health has a complex pedigree, beginning with the assertion in the Preamble to the 1946 Constitution of the World Health Organization (WHO) that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”²⁷ The right to health was reaffirmed as “a fundamental hu-

19. *See infra* notes 28-50 and accompanying text.

20. *See infra* Part I.A.

21. *See infra* Part I.B.

22. *See infra* notes 54-55 and accompanying text.

23. Dinah Shelton, *International Law and ‘Relative Normativity’*, in *INTERNATIONAL LAW* 135, 161 (Malcolm Evans ed., 4th ed., 2014).

24. *Id.* at 162.

25. *Id.*

26. *Id.* at 163.

27. World Health Org. [WHO] Constitution, pmbl.

man right” in the 1978 Declaration of Alma-Ata on Primary Health Care, which stated “that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.”²⁸

Two years after the adoption of the WHO Constitution, the right to health was incorporated as a component of the right to an adequate standard of living in the 1948 Universal Declaration of Human Rights (UDHR).²⁹ It has since been included in many U.N. human rights treaties, primarily the International Covenant on Economic, Social, and Cultural Rights (ICESCR) of 1966, which differed from the UDHR in framing the right to health as a standalone right, rather than as a component of the right to an adequate standard of living.³⁰ The ICESCR also went well beyond health care by defining the right to health as “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,” and enumerating five “steps to be taken...to achieve the full realization of this right.”³¹ Variations on the ICESCR’s formulation are found in the other major U.N.³² and regional human rights treaties.³³

A. Normative Expansion Through General Comments

Thus, as mentioned in the previous paragraph, by 1966 the right to health had expanded from medical care to a distinct right with specific health goals integral to its realization. Little progress was made in the 1970s and 1980s, during which time the United Nations’ approach to economic, social, and cultural rights was described as one of “hypocrisy and longwindedness.”³⁴ The role assigned to the Specialized Agencies in the ICESCR was of no value in monitoring or clarifying the normative content of the right to health, considering that WHO’s report did not, in legal scholar and human rights practitioner Philip Alston’s

28. WHO International Conference on Primary Health Care, Declaration of Alma-Ata art. 1 (Sept. 12, 1978).

29. G.A. Res. 217 (III) A, Universal Declaration of Human Rights art. 25(1), (Dec. 10, 1948) (“Everyone has the right to a standard of living adequate for the health 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.”).

30. *Id.*

31. See ICESCR, *supra* note 14, art. 12.

32. See sources cited in *supra* note 14..

33. See sources cited in *supra* note 15.

34. Phillip Alston, *Out of the Abyss: The Challenges Confronting the New U.N. Committee on Economic, Social and Cultural Rights*, 9 HUMAN RTS. Q. 332, 379 (1987) (quoting U.N. Joint Inspection Unit head Maurice Bertrand).

view, provide “any information whatsoever that would assist the Committee to come to grips with the difficult concept of the right of access to health care” nor “reference of any kind to the relevant reports of [S]tates [P]arties to the Covenant.”³⁵

The next stage of the right’s development commenced with the creation of the Committee on Economic, Social, and Cultural Rights (CESCR) in 1985.³⁶ Under Philip Alston’s chairmanship, it organized a “day of general discussion” on the right to health in 1993,³⁷ and in 2000, adopted General Comment Number 14 on the Right to Health.³⁸

General Comment Number 14 provided a framework that has been widely accepted to identify the meaning of the right to health: “a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.”³⁹ It also defined “highest attainable standard” as “tak[ing] into account both the individual’s biological and socio-economic preconditions and a State’s available resources.”⁴⁰ Highest attainable standard is further explicated through a set of “interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State [P]arty” relating to availability, accessibility, acceptability, and quality of health facilities, goods, and services.⁴¹

The Committee explains that the “availability” requirement refers to facilities, goods, and services of the health system, such as hospitals, clinics, trained medical and professional personnel, and essential drugs, as well as to the underlying determinants of health, such as safe and potable drinking water and adequate sanitation.⁴² The “accessibility” requirement has four overlapping dimensions: accessibility without discrimination, physical accessibility, economic accessibility (affordability), and the accessibility of health-related information.⁴³ The “acceptability” requirement refers to respect for medical ethics and cul-

35. *Id.* at 367.

36. The CESCR was created to monitor the ICESCR. Economic and Social Council Res. 1985/17 (May 28, 1985).

37. U.N. ESCOR, Comm. of Econ., Soc. & Cultural Rts. (CESCR), 9th Sess., 41st mtg. at 2, U.N. Doc. E/C.12/1993/SR.41 (Dec. 6 1993); U.N. ESCOR, CESCR, 9th Sess., 42nd mtg. at 1, 3, U.N. Doc. E/C.12/1993/SR.42 (Dec. 6 1993). It should be noted that the purpose of the day of discussion was “to provide material for a general comment.” CESCR, E/C.12/1993/SR.41, at 2.

38. U.N. Econ. and Soc. Council (ESC), CESCR, *General Comment 14: The Right to the Highest Attainable Standard of Health*, U.N. Doc. E/C.12/2000/4 (July 4, 2000) [hereinafter CESCR, *General Comment 14*].

39. *Id.* ¶ 9.

40. *Id.*

41. *Id.* ¶ 12.

42. *Id.* ¶ 12(a).

43. *Id.* ¶ 12(b).

tural sensitivities.⁴⁴ Finally, the “quality of care” requirement refers to health facilities, goods, and services of good quality and scientifically and medically appropriate, such as the availability of “skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.”⁴⁵

These four dimensions are quite congruent with the practice of public health, as exemplified by the “building blocks” of health systems defined by WHO.⁴⁶ Expanding on the dimensions of the right to health, the CESCR enumerated how governments should comply with their obligation to respect, protect, and fulfill the right to health.⁴⁷ These three obligations (with the third sometimes expanded into the obligations to promote or facilitate and to provide) have become the standard approach of treaty bodies and thematic rapporteurs.⁴⁸ Drawing on the building blocks of health systems referred to above, the obligation to respect primarily applies to the health workforce, leadership, and governance; that to protect applies to government action to assure third party compliance, such as access to essential medicines from pharmaceutical companies; the obligation to promote applies to health information systems; and that to fulfill applies to service delivery and financing.⁴⁹

While these obligations are to be met within the context of progressive realization of the right to health, the CESCR took the bold step of enumerating a subset of six obligations belonging to a “core minimum” and a set of five “obligations of comparable priority,” listed in Table 1 below, which are not subject to progressive realization.⁵⁰ Complementing and expanding on the work of the CESCR, the United Nations Special Rapporteur on the right to health drew attention to “the right to control one’s health, including the right to be free from non-consensual medical treatment and experimentation,” and specific entitlements in areas such as maternal, child, and reproductive health; occupational

44. *Id.* ¶ 12(c).

45. *Id.* ¶ 12(d).

46. WHO identifies six building blocks for health systems: (1) service delivery, (2) health workforce, (3) health information systems, (4) access to essential medicines, (5) financing, and (6) leadership/governance. WHO, MONITORING THE BUILDING BLOCKS OF HEALTH SYSTEMS: A HANDBOOK OF INDICATORS AND THEIR MEASUREMENT STRATEGIES, vi (2010) [hereinafter WHO, MONITORING THE BUILDING BLOCKS OF HEALTH SYSTEMS].

47. See CESCR, *General Comment 14*, *supra* note 38, ¶ 33.

48. As summarized by the Office of the High Commissioner for Human Rights, “By becoming parties to international treaties, States assume obligations and duties under international law to respect, to protect and to fulfill human rights.” *International Human Rights Law*, OFF. HIGH COMM’N HUM. RTS. (OHCHR) (2016),

<http://www.ohchr.org/EN/ProfessionalInterest/Pages/InternationalLaw.aspx>

[<https://perma.cc/Y86Q-7WXB>].

49. See WHO, MONITORING THE BUILDING BLOCKS OF HEALTH SYSTEMS *supra* note 46.

50. See *infra* Section III.B, Table 1.

health; and prevention, treatment, and control of diseases, including access to essential medicines.⁵¹

A similar enumeration of these features of the normative content was included in the Office of the United Nations High Commissioner for Human Rights (OHCHR) study on human rights indicators, which identified five attributes for the right to health: “sexual and reproductive health,” “child mortality and health care,” “natural and occupational environment,” “prevention, treatment and control of diseases,” and “accessibility to health facilities and essential medicines.”⁵²

B. Purported Normative Expansion Through “New” Rights

Just as it would be foolish to heed Fukuyama’s aforementioned suggestion to “abandon talk of rights altogether[.]”⁵³ there are also disadvantages to succumbing to the temptation to conclude that everything that alleviates human suffering should be a human right. Drawing upon the concept of quality control, in 1984 Philip Alston articulated a middle ground, arguing that if a norm is to be considered for formal recognition as a human right, it should meet the following seven criteria:

- (1) Reflect a fundamentally important social value;
- (2) Be relevant, inevitably to varying degrees, throughout a world of diverse value systems;
- (3) Be eligible for recognition on the grounds that it is an interpretation of [U.N.] Charter obligations, a reflection of customary law rules or a formulation that is declaratory of general principles of law;
- (4) Be consistent with, but not merely repetitive of, the existing body of international human rights law;
- (5) Be capable of achieving a very high degree of international consensus;
- (6) Be compatible or at least not clearly incompatible with the general practice of states; and
- (7) Be sufficiently precise as to give rise to identifiable rights and obligations.⁵⁴

Within two years of Alston’s articulation, the General Assembly

51. Paul Hunt (Special Rapporteur for the Comm. of Human Rts.), *Report on Economic, Social and Cultural Rights: The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, ¶¶ 22–24, U.N. Doc. E/CN.4/2003/58 (Feb. 13, 2003).

52. OHCHR, *Human Rights Indicators: A Guide to Measurement and Implementation*, U.N. Doc. HR/PUB/12/5 (2012) (Rajeev Malhotra) [hereinafter OHCHR, *Human Rights Indicators*].

53. Fukuyama, *supra* note 5.

54. Philip Alston, *Conjuring Up New Human Rights: A Proposal For Quality Control*, 78 AM. J. INT’L. L. 607, 616 (1984); see also UPENDRA BAXI, *What is Living and Dead in Relativism?*, in THE FUTURE OF HUMAN RIGHTS, 106–09 (2nd. ed., 2006).

adopted a set of guidelines to be used in developing international instruments in the field of human rights, urging that such instruments should:

- Be consistent with the existing body of international human rights law;
- Be of fundamental character and derive from the inherent dignity and worth of the human person;
- Be sufficiently precise to give rise to identifiable and practicable rights and obligations;
- Provide, where appropriate, realistic and effective implementation machinery, including reporting systems;
- Attract broad international support.⁵⁵

One positive example conforming to the guidelines is the U.N. Convention on the Rights of Persons with Disabilities (CRPD).⁵⁶ Many rights, such as access to justice, or freedom from torture, are reiterated in the CRPD for the purposes of providing a full catalog of human rights for persons with disabilities.⁵⁷ Other rights in the CRPD are specific to the disabled, and are “new” in the sense that they provide a legally grounded normative expansion of human rights, including “access to a range of in-home, residential and other community support services,”⁵⁸ and “access . . . to quality mobility aids, devices, assistive technologies and forms of live assistance and intermediaries.”⁵⁹ Taken together, the rights in the CRPD conform to all five guidelines in the 1986 resolution.⁶⁰

The specific elements named by the Committee expand considerably on both the UDHR reference to “medical care” and “security in the event of . . . sickness,” as well as the CESC Article 12 formulations, without using the language of “new” or even “derivative” human rights. They are interpretations by those entrusted with monitoring and promoting implementation of treaty-based rights regarding what should be expected from each state in accordance with its legal requirement “to take steps, individually and through international assistance and co-operation . . . to the maximum of its available resources,” as required by

55. G. A. Res. 41/120, ¶¶ 1–5 (Dec. 1986).

56. G. A. Res. 61/106, Conv. on the Rights of Persons with Disabilities and Optional Protocol, U.N. Doc. A/RES/61/106 (May 3, 2008) [hereinafter ICRPD].

57. See ICRPD, *supra* note 56, art. 10 (Right to Life); *id.* art. 12 (Equal Recognition Before the Law); *id.* art. 13 (Access to Justice); *id.* art. 14 (Liberty and Security of Person); *id.* art. 15 (Freedom from Torture or Cruel, Inhuman or Degrading Treatment or Punishment); *id.* art. 16 (Freedom from Exploitation, Violence and Abuse); *id.* art. 17 (Protecting the Integrity of the Person); Article 18 (Liberty of Movement and Nationality).

58. See ICRPD, *supra* note 56, art. 19(b).

59. See ICRPD, *supra* note 56, arts. 19(b), 20(b).

60. See *supra* note 55 and accompanying text.

the ICESCR, to achieve progressively “the highest attainable standard of health.”⁶¹

In addition to the expansion of the content of the right to health through legal interpretation, several academic and civil society efforts have added elements of the right to health, often using the language of “derivative rights” or “new rights,” as discussed in the next Part.

II. EXPANDING THE NORMATIVE CONTENT OF THE RIGHT TO HEALTH THROUGH NEW AND DERIVATIVE RIGHTS

To illustrate the trend of defining derivative and new rights that build on the right to health, this Part discusses the examples of the rights to water and sanitation, sexual and reproductive health, safe motherhood, tobacco control, essential medicines and devices, essential and emergency surgery, and the right of the newborn to screening for cystic fibrosis.

A. Water and Sanitation

The political will to formulate access to water and sanitation as human rights resulted from governments and civil society at large making these issues a priority.⁶² For example, the U.N. Development Programme, in its *Human Development Report 2006, Beyond Scarcity: Power, Poverty and the Global Water Crisis*, called attention to the 1.2 billion people who do not have access to safe water and the 2.6 billion who do not have access to sanitation. The report forthrightly commented, “The starting point and the unifying principle for public action in water and sanitation is the recognition that water is a basic human right.”⁶³

The case for the right to water and sanitation is novel in that the pri-

61. See ICESCR, *supra* note 14, arts. 2, 12.

62. *Goal 7: Ensure Environmental Sustainability*, U.N. MILLENNIUM DEVELOPMENT <http://www.un.org/millenniumgoals/enviro.html> [<https://perma.cc/F27H-DCMQ>] (last visited Aug. 12, 2016) (Target 7.C aims to “halve, by 2015, the proportion of the population without sustainable access to safe drinking water and basic sanitation,” which the United Nations reported had been met. From 1990 to 2015, 2.1 billion people have benefited, although 2.4 billion were still using unimproved sanitation) (Millennium Development Goal 7 also included Target 7.D, “achieve, by 2020, a significant improvement in the lives of at least 100 million slum dwellers,” the United Nations reported that “more than 320 million people living in slums gained access to improved water sources, improved sanitation facilities, or durable or less crowded housing, thereby exceeding the MDG target”).

63. U.N. Human Dev. Rep. Off., United Nations Human Development Report 2006, *Beyond Scarcity: Power, Poverty and the Global Water Crisis* 60 (United Nations Development Programme 2006), <http://www.undp.org/content/dam/undp/library/corporate/HDR/2006%20Global%20HDR/HDR-2006-Beyond%20scarcity-Power-poverty-and-the-global-water-crisis.pdf> [<https://perma.cc/NV3P-ATCH>].

mary human rights instruments do not refer to access to potable water for drinking and adequate systems of sanitation as a human right, except as an implied element of the right to an adequate standard of living, including food and health.⁶⁴ This was the case until CESCR adopted General Comment Number 15 on the Right to Water⁶⁵ and the General Assembly adopted Resolution 64/292.⁶⁶ The CESCR noted: “Water is a limited natural resource and a public good fundamental for life and health. The human right to water is indispensable for leading a life in human dignity. It is a prerequisite for the realization of other human rights.”⁶⁷ It also stated, “The right to water has been recognized in a wide range of international documents, including treaties, declarations and other standards.”⁶⁸

Thus, the right to water attained full recognition as a human right because it meets all seven of Alston’s criteria,⁶⁹ and all five of the guidelines endorsed by the General Assembly.⁷⁰ It began, however, as a derivative right—a necessary extension of the rights to an adequate standard of living and to health, or, as noted in General Comment Number 14, an underlying determinant of health⁷¹—and evolved into a free-standing right in General Assembly Resolution 64/292, without becoming a binding norm through treaty obligations.⁷² The same may be said for the General Assembly’s recognition of sanitation as a separate human right in Resolution 70/169.⁷³ According to Resolution 70/169, “[T]he human right to sanitation entitles everyone, without discrimination, to have physical and affordable access to sanitation, in all spheres of life, that is safe, hygienic, secure, socially and culturally acceptable

64. CESCR, *General Comment 15: The Right to Water (Arts. 11 and 12 of the International Covenant on Economic, Social and Cultural Rights)*, ¶ 3, U.N. Doc. E/C.12/2002/11 (2002) [hereinafter CESCR, *General Comment 15*].

65. *See id.*

66. G.A. Res. 64/292, 2010 The Human Right to Water and Sanitation (Aug. 3, 2010).

67. *See CESCR, General Comment 15, supra* note 64, ¶ 1.

68. *Id.* ¶ 4.

69. *See Alston, supra* note 54, at 616.

70. *See G.A. Res. 41/120, supra* note 55.

71. *See CESCR, General Comment 14, supra* note 38, ¶ 11.

72. A General Assembly resolution may be evidence of evolving state practice and contribute to the crystallization of a customary norm of international law. On the legal nature of General Assembly resolution, *see, e.g.*, C. M. Chinkin, *The Challenge of Soft Law: Development and Change in International Law*, 38 INT’L & COMP. L.Q. 850, 866 (1989); Stephen M. Schwebel, *The Effect of Resolutions of the U.N. General Assembly on Customary International Law*, 73 AM. SOC’Y INT’L L. PROC. 301, 309 (1979).

73. *Proper Sanitation Becomes Separate UN Human Right In Enhanced Fight Against Deadly Infections*, UNITED NATIONS NEWS CENTRE (Dec. 31, 2015), <http://www.un.org/apps/news/story.asp?NewsID=52924#.V4LVq5MrKXQ> [<https://perma.cc/X72U-8V47>].

and that provides privacy and ensures dignity.”⁷⁴

Whether considered separately or together, the recognition of these rights corresponds more to *lex ferenda*, that is, a “soft” norm evolving toward “hard” law through state practice that can crystallize into binding customary international law. International law professor, Chinkin, explains that this “soft” form of obligation “may facilitate reaching a political consensus, bring an issue into the international agenda, define the area of international concern, and provide guidelines for behavior that may generate the requisite practice for a rule of customary international law.”⁷⁵ Because of this evolution, the right to water and sanitation does not need to attach to the right to health to be valid, unlike the other candidate-rights discussed below.

B. Sexual and Reproductive Health and Rights

Considerable normative expansion by treaty bodies, as well as U.N. agencies and conferences has occurred with respect to sexual and reproductive health and rights.⁷⁶ In General Comment Number 14 to ICESCR Article 12.2 (a), the CESCR interpreted the “right to maternal, child and reproductive health,” as “requiring measures to improve . . . sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information.”⁷⁷

These observations build on the groundbreaking Principle 8 of the Program of Action of the 1994 Cairo International Conference on Population and Development,⁷⁸ and on the Beijing Declaration and Platform

74. G.A. Res. 70/169, The Human Rights to Safe Drinking Water and Sanitation, ¶ 2 (Feb. 26, 2016).

75. Christine Chinkin, *Sources*, in INTERNATIONAL HUMAN RIGHTS LAW 92 (Daniel Moeckli, Sangeeta Shah & Sandesh Sivakumaran eds., 2d ed., 2014).

76. See *supra* notes 51 (on the special rapporteur) and 52 (on OHCHR attributes) and accompanying text.

77. CESCR, *General Comment* 14, *supra* note 38, ¶ 14. General Comment Number 14 also refers to “full range of high quality and affordable health care, including sexual and reproductive services” as part of the “national strategy for promoting women’s right to health throughout their life span.” *Id.* ¶ 21. This recommendation is echoed in General Recommendation 24 of the Committee on the Elimination of All Form Discrimination Against Women. Comm. on the Elimination of Discrimination Against Women, Rep. of the Work of Its Twentieth and Twenty-first Sess., U.N. Doc. A/54/38/Rev.1 (1999).

78. International Conference on Population and Development, *Programme of Action*, princ. 8, U.N. Doc. A/CONF.171/13 (Sept. 5–13, 1994):

States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health. Reproductive health-care programmes should provide the widest range of services without any form of coercion. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and

for Action, adopted by the Fourth World Conference on Women in 1995,⁷⁹ in which the participating governments recognized and reaffirmed “the right of all women to control all aspects of their health, in particular their own fertility,”⁸⁰ and expressed their determination to “enhance women’s sexual and reproductive health.”⁸¹ In addition to the Declaration, the Beijing Conference adopted a Platform of Action, stating that reproductive health “implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so,” including the right “to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice.”⁸² The document attaches particular importance to “basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children.”⁸³

Even though the terms “reproductive rights” and “sexual rights” are frequently used to analyze these issues, they are usually linked with the right to health and other related rights, as the examples above illustrate.⁸⁴ At least in some contexts, however, as Alice Miller and Mindy Roseman, respectively Co-Director of the Global Health Justice Partnership and Director of the Gruber Program on Global Justice and Women’s Rights at Yale Law School, point out, this structure may be too limited: “Health as the frame for sexual rights may have reached the end of its utility in the arguments for women’s rights to decision-making in regard to abortion, where autonomy may be better grounded in equality, non-discrimination, dignity, and privacy, as opposed to primarily grounded in health.”⁸⁵ They note that “sexuality, gender and reproduction joined to rights do indeed challenge and shift and potentially reconstitute the nature of the state and state power,” while observing that “NGOs’ practice of picking fights based on a belief that political debates can usefully function as markers of legitimation of new

means to do so.

79. Fourth World Conference on Women, *Beijing Declaration and Platform for Action*, ¶ 17, U.N. Doc. A/CONF.177/20/Rev.1 (Sept. 15, 1995).

80. *Id.* Annex I, ¶ 17, Annex II ¶ 92.

81. *Id.* Annex I, ¶ 30.

82. *Id.*, Annex II, ¶ 94.

83. *Id.* Annex II, ¶ 95, ¶ 106(e) (emphasizing efforts to make healthcare services for family planning more accessible, available, and affordable).

84. *See supra* notes 80-83 and accompanying text.

85. Alice M. Miller & Mindy J. Roseman, *Sexual and Reproductive Rights at the United Nations: Frustration or Fulfillment?*, 19 REPROD. HEALTH MATTERS 102, 110–111 (2011); *see also* Alice M. Miller, *Sexual but Not Reproductive: Exploring the Junction and Disjunction of Sexual and Reproductive Rights*, 4 HEALTH & HUM. RTS. 68, 68–109 (2000) (describing the challenges of defining the scope and content of “sexual rights” in a changing political landscape).

rights.”⁸⁶

The CESCR expanded the normative content of reproductive and sexual rights further in its General Comment Number 22, adopted in May 2016.⁸⁷ The Committee expressed its concern over “numerous legal, procedural, practical and social barriers, [as a result of which] access to the full range of sexual and reproductive health facilities, services, goods and information is seriously restricted,” and “the full enjoyment of the right to sexual and reproductive health remains a distant goal for millions of people, especially for women and girls, throughout the world.”⁸⁸ Although the Committee refers to “the right to sexual and reproductive health,” it makes no claim that such a right is autonomous; rather the right “is an integral part of the right of everyone to the highest attainable physical and mental health.”⁸⁹ The need to affirm the normative content of this right is clear, as demonstrated by the Committee’s citing as “examples of violations of the obligation to respect . . . the establishment of legal barriers impeding access by individuals to sexual and reproductive health services, such as the criminalization of women undergoing abortions and the criminalization of consensual sexual activity between adults.”⁹⁰ These and the other features of the right to sexual and reproductive health contained in General Comment Number 22 are, like those of General Comment Number 14, based on legitimate normative expansion through non-binding norms.⁹¹

Excessive enthusiasm over the “legitimation of new rights” relating to sexuality, gender, and reproduction⁹² emerged in early 2016 when a flurry of websites rejoiced that a United Nations Committee had “declared” abortion a human right.⁹³ Such enthusiasm is understandable for supporters of abortion rights, but it gave the misleading impression

86. Miller & Roseman, *supra* note 85, at 114.

87. ESC, CESCR, *General Comment 22: On the Right to Sexual and Reproductive Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)*, U.N. Doc. E/C.12/GC/22 (May 2, 2016) [hereinafter CESCR, *General Comment 22*].

88. *Id.*, ¶ 2.

89. *Id.*, ¶ 11.

90. *Id.*, ¶ 57.

91. See *supra* notes 23-26 and accompanying text.

92. See Miller & Roseman, *supra* note 85.

93. Natasha Hakimi Zapata, *Abortion Declared a Human Right by United Nations Committee*, TRUTHDIG (Feb. 3, 2016).

http://www.truthdig.com/eartothe-ground/item/abortion_declared_a_human_right_by_united_nations_committee_20160203 [<https://perma.cc/9QL7-3TPT>]; see also Lauren Barbato, *United Nations Committee Affirms Abortion as a Human Right*, HUFFINGTON POST (Jan. 25, 2016), http://www.huffingtonpost.com/david-a-grimes/united-nations-committee-affirms-abortion-as-a-human-right_b_9020806.html [<https://perma.cc/N3AR-B9SF>]; David A. Grimes, *A United Nations Committee Officially Ruled Abortion a Human Right*, BUSTLE (Dec. 6, 2014), <http://www.bustle.com/articles/52634-un-declares-abortion-rights-are-human-rights-promising-to-support-reproductive-rights-worldwide> [<https://perma.cc/7LVY-FSAZ>].

that a new right had been proclaimed.⁹⁴ What actually occurred was, after nearly a decade of delay, the Peruvian government agreed to pay compensation to K.L., a Peruvian minor, who was denied a legal abortion of a pregnancy that exposed her to life-threatening risks and severe psychological consequences, resulting in the birth of a baby who died after only four days.⁹⁵ The Centre for Reproductive Rights, the Latin American and Caribbean Committee for the Defence of Women's Rights, and the Counselling Centre for the Defence of Women's Rights, represented K.L. in a case brought under the Option Protocol to the International Covenant on Civil and Political Rights.⁹⁶ In 2005, the Human Rights Committee found that "the facts before it disclose a violation of [A]rticles 2 [effective remedy], 7 [cruel, inhuman or degrading treatment or punishment], 17 [privacy, family, home, or correspondence], and 24 [measures of protection for children]"⁹⁷ and declared that "the State [P]arty is required to furnish the author with an effective remedy, including compensation."⁹⁸

Despite the victory for abortion-rights advocates, the Committee has no jurisdiction over health rights and in no way created a new human right to abortion.⁹⁹ As demonstrated by K.L.'s case and other similar cases,¹⁰⁰ treaty bodies contribute to expanding the normative content of the right to health, both by issuing general comments and formulating their views on cases brought under complaints procedures, including enhancing the protection of health-related rights through protection of civil and political rights, without crossing the line and proclaiming "new" rights.

94. See sources cited *supra* note 93.

95. Karen Noelia Llantoy Huaman v. Peru, ¶¶ 2.1–2.6, Communications No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (Nov. 2005).

96. *Id.* ¶ 1.

97. *Id.* ¶ 7.

98. *Id.* ¶ 8.

99. *UN Announces That Peru Will Compensate Woman in Historic Human Rights Abortion Case*, UNITED NATIONS NEWS CENTRE (Jan. 18, 2016), <http://www.un.org/apps/news/story.asp?NewsID=53033#.V1jxgVd7zn0> [https://perma.cc/A44P-F249].

100. See e.g., *A, B and C v. Ireland*, 2010-VI Eur. Ct. H.R. 185, 190. In *A, B and C v. Ireland*, the court held that Ireland violated Article 8 of the European Convention on Human Rights (Right to Privacy) because it:

failed to comply with their positive obligation to secure to the . . . applicant effective respect for her private life by reason of the absence of any implementing legislative or regulatory regime providing an accessible and effective procedure by which [she] could have established whether she qualified for a lawful abortion. *Id.*

The court clearly did not establish a separate human right to abortion.

C. Safe Motherhood

While the ICESCR includes the “provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child,”¹⁰¹ and General Comment Number 14 mentions “reproductive, maternal (pre-natal as well as post-natal) and child health care,” a trend to incorporate the WHO standard of “safe motherhood” as a component of the right to health has emerged in the literature. The U.N. Fund for Population Activities explicitly endorsed this trend: “Working for the survival of mothers is a human rights imperative.”¹⁰² It even entitled its 2014 *State of the World’s Midwifery* report: “A Universal Pathway. A Woman’s Right to Health.”¹⁰³

Professor and Co-Director of the International Reproductive and Sexual Health Law Programme in Toronto, Rebecca Cook, laid the groundwork for this approach, when in 1998 she wrote the following:

Many of the human rights that currently exist in national constitutions and regional and international human rights treaties can be applied to advance safe motherhood. However, no national constitution or international human rights convention has established safe motherhood as a distinct human right. An explanation for this is that modern national constitutions and international legal instruments in which human rights are expressed evolved in a gendered world.¹⁰⁴

She argued forcefully for “advancing safe motherhood through human rights” rather than articulating a human right to safe motherhood.¹⁰⁵ The same year Professor of Obstetrics and Gynecology, Mahmoud Fathalla, wrote an article titled “Women Have a Right to Safe Motherhood.”¹⁰⁶ He later authored another article in which he argued that “the health profession should collaborate with legal human rights advocates . . . [i]n advocating for *safe motherhood as a human right*.”¹⁰⁷

101. See ICESCR, *supra* note 14, art. 12.2(a).

102. Overview, U.N. FUND FOR POPULATION ACTIVITIES (UNFPA) <http://republic-of-moldova.unfpa.org/public/cache/offonce/home/mothers/pid/4381.jsessionid=B7C06BBB06AA34BB66DC7FC1FD7BA9BB.jahia01> (citing UNFPA, *Stepping up Efforts to Save Mothers’ Lives* (2014), http://countryoffice.unfpa.org/filemanager/files/sudan/facts/maternal_health.pdf) (last visited Aug. 14, 2016).

103. UNFPA, *The State of the World’s Midwifery 2014: A Universal Pathway. A Woman’s Right to Health* (June 2014), https://www.unfpa.org/sites/default/files/pub-pdf/EN_SoWMy2014_complete.pdf [https://perma.cc/LNZ4-A68R].

104. Rebecca J. Cook, *Human Rights Law and Safe Motherhood*, 5 EUR. J. HEALTH L. 357, 359 (1998).

105. See *id.* at 359, 370.

106. Mahmoud F. Fathalla, *Women Have A Right to Safe Motherhood*, in PLANNED PARENTHOOD CHALLENGES: INTERNATIONAL PLANNED PARENTHOOD FEDERATION 1–2 (1998).

107. Mahmoud F. Fathalla, *Human Rights Aspects of Safe Motherhood*, 20 BEST PRACTICE & RESEARCH, CLINICAL OBSTETRICS & GYNAECOLOGY 409, 412 (2006) (emphasis added).

In 2001, Cook further developed the scope of these human rights in a book she co-authored for WHO entitled *Advancing Safe Motherhood*.¹⁰⁸ The next year she co-authored “Human Rights to Safe Motherhood” with Bernard Dickens, in which they identified women’s rights to life, liberty, and security of the person, health, maternity protection, and non-discrimination, and the “five critical rights the observance of which would facilitate safe motherhood.”¹⁰⁹ Reviewing safe motherhood programs over a twenty-year period, midwife and international consultant in maternal and newborn health, Gaynor Maclean, asserted that, “Safe Motherhood is currently considered increasingly as a basic human right.”¹¹⁰

As the Special Rapporteur on the right to health pointed out in 2006:

Maternal mortality is one of a small number of right-to-health issues where human rights experts and health policymakers have engaged extensively and constructively with each other. These efforts deserve applause and further support In contrast, the human rights community has given less attention to the traditional human rights techniques for addressing maternal mortality. Naming and shaming, campaigning, and court-based approaches also have an important role to play in strengthening claims, and enhancing accountability for, the reduction of maternal mortality.¹¹¹

In sum, safe motherhood and reduction of maternal mortality have been widely accepted by governments, international agencies, and advocacy and service-delivery groups as an essential component of the right to health, and sometimes asserted as a separate human right.¹¹²

D. Tobacco Control

The argument for tobacco control as an “emerging human right” or “a right integral to the right to health” begins—consistent with Alston’s first criterion—by drawing attention to the burden of disease from tobacco use.¹¹³ In making the case for an “emerging human right to tobacco control,” Carolyn Dresler and I took as our starting point that to-

108. Rebecca J. Cook, Bernard M. Dickens, O. Andrew F. Wilson, & Susan E. Scarrow, WHO, *Advancing Safe Motherhood Through Human Rights* (2001).

109. Rebecca J. Cook & Bernard M. Dickens, *Human Rights to Safe Motherhood*, 76 INT’L J. OF GYNECOLOGY & OBSTETRICS 225, 225 (2002).

110. Gaynor Maclean, *A Historical Overview of the First Two Decades of Striving Towards Safe Motherhood*, 1 SEXUAL & REPROD. HEALTHCARE 7, 7 (2010).

111. Paul Hunt (Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health), *Rep. of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, ¶¶ 32–33, U.N. Doc. A/61/338 (Sept. 13, 2006).

112. See *supra* notes 106–111 and accompanying text.

113. Carolyn Dresler & Stephen P. Marks, *The Emerging Human Right to Tobacco Control*, 28 HUM. RTS Q. 599, 559 (2006).

bacco is “the only legal product that, when used as intended, kills fifty - percent of its consumers. Over five million die from tobacco-related deaths every year. It is the leading preventable cause of death in the world.”¹¹⁴ Moreover, there is a parallel with the right to water insofar as “the essential components are already emerging in the practice of states and international institutional institutions.”¹¹⁵ It was probably an exaggeration to say “Both access to water and tobacco control are so essential to the rights to life and health that the protection of those rights is inconceivable without acknowledging the specificity of these two derivative human rights.”¹¹⁶ The right to water has risen from a derivative to an autonomous right, whereas tobacco control continues to be advanced as an essential component of the right to health.

Scholarly literature pertaining to tobacco control has benefited from several thoughtful contributions by Melissa Crow,¹¹⁷ Rangita de Silva de Alwis, and Richard Daynard.¹¹⁸ Daynard and de Silva de Alwis provide an exhaustive overview of domestic and international litigations relating to tobacco use, and conclude that tobacco control has been established by both customary international law and human rights treaty law, which includes a duty of due diligence in implementing treaty provisions, and accountability for acts of omission in relation to the proper implementation of relevant legislation on tobacco control.¹¹⁹ They explain, “Tying the right to be free of secondhand smoke with the right to life raises this right to a customary human rights norm, or a peremptory norm, which is considered non-derogable and therefore imposes binding obligations on countries including the United States that have not ratified certain treaties.”¹²⁰

The U.N. system has tended to accept tobacco control as a component of the right to health beginning with CESCR’s brief mention in General Comment Number 14 that the ICESCR “discourages . . . the use of tobacco, drugs and other harmful substances.”¹²¹ It also considered that

114. *Id.* at 649. The annual deaths from smoking are now estimated at nearly 6 million. *See Tobacco Fact Sheet No. 339*, WHO (June 2016), <http://www.who.int/mediacentre/factsheets/fs339/en/> [<https://perma.cc/3PVS-3N6M>].

115. *See* Dresler & Marks, *supra* note 113 at 651. It was probably an exaggeration to say, however, that “[b]oth access to water and tobacco control are so essential to the rights to life and health that the protection of those rights is inconceivable without acknowledging the specificity of these two derivative human rights.” *Id.*

116. *See* Dresler & Marks, *supra* note 113, at 629, 651.

117. *See* Melissa E. Crow, *Smokescreens and State Responsibility: Using Human Rights Strategies to Promote Global Tobacco Control*, 29 *YALE J. INT’L L.* 209 (2004).

118. *See* Rangita de Silva de Alwis & Richard Daynard, *Reconceptualizing Human Rights to Challenge Tobacco*, 17 *MICH. ST. J. INT’L L.* 291 (2008-2009).

119. *See* de Silva & Daynard, *supra* note 118 at 373.

120. *See id.*

121. *See* CESCR, *General Comment 14*, *supra* note 38, ¶ 15 (relating to article 12.2(b)

“the failure to discourage production, marketing and consumption of tobacco” would constitute a “failure of a State to take all necessary measures to safeguard persons within their jurisdiction from infringements of the right to health by third parties” and thus constitute a violation “of the obligation to protect.”¹²²

Recommendations contained in shadow reports submitted to the CESCR by the Human Rights and Tobacco Control Network (HRTCN) and the O’Neill Institute, and in other treaty bodies, have on occasion been incorporated into the concluding observations as part of monitoring government compliance with their right-to-health obligations.¹²³ This use of shadow reports to hold governments accountable for appropriate tobacco control policies and practices as part of their obligation under Article 12 of the ICESCR is a clear example of the willingness of the principal treaty body to grow the normative content of the right to health to include tobacco control.

While the magnitude of preventable deaths—now some six million annually—might justify treating tobacco control like the right to water and “reconceptualiz[ing] human rights to challenge tobacco,” as de Alwis and Daynard recommend,¹²⁴ the political will is lacking to move toward a separate, legally-binding human right instrument on tobacco control, separate from the right to health and the treaty obligations of the Framework Convention on Tobacco Control.¹²⁵

E. Essential Medicines

Similarly, the argument for a human right to essential medicines begins with the global burden of disease—nearly two billion people do not have access to essential medicines, and an estimated four million people in Africa and Southeast Asia could be saved annually if diagnosis and treatment with appropriate medicines were available.¹²⁶ While the proportion of the world’s population without access to life-saving and other essential medicines has decreased from one-half in 1975 to about one-

(“healthy natural and workplace environments”).

122. See *id.* ¶ 51 (although the Committee does not cite the regulation of tobacco companies as an example).

123. See Carolyn Dresler, Harry Lando, Nick Schneider & Hitakshi Sehgal, *Human Rights Based Approach to Tobacco Control*, 21 TOBACCO CONTROL: 20TH ANNIVERSARY ISSUE 74 (2012); Stephen P. Marks, *Invited Commentary*, 21 TOBACCO CONTROL: 20TH ANNIVERSARY ISSUE 212 (2012).

124. See de Silva & Daynard, *supra* note 119, at 292–293.

125. WHO, Framework Convention on Tobacco Control, May 21, 2003, 2302 U.N.T.S. 166.

126. See Stephen P. Marks, *Access to Essential Medicines as a Component of the Right to Health*, in 3 SWISS HUMAN RIGHTS BOOKS: REALIZING THE RIGHT TO HEALTH 95 (Andrew Clapham, Mary Robinson, Claire Mahon, Scott Jerbi eds., 2009) [hereinafter Marks, *Access to Essential Medicines*].

third today, the absolute number has remained constant at approximately two billion people.¹²⁷ The U.N. General Assembly echoed concerns about access to medicines in its resolutions on Global Health and Foreign Policy, in which it reaffirmed the following:

the right of every human being . . . to . . . health . . . and to the continuous improvement of living conditions, with particular attention to the alarming situation of millions of people for whom access to medicines remains a distant goal, in particular vulnerable populations and destitute people.¹²⁸

The prominence of access to essential medicines as a human right issue is due, in large part, to the alliance of health and human rights advocacy in relation to the HIV/AIDS pandemic.¹²⁹ In 2001 the United Nations took three major actions. First, the Commission on Human Rights adopted a resolution on access to medication in the context of pandemics such as HIV/AIDS.¹³⁰ Second, the Office of the High Commissioner issued a report on the impact of the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement on human rights.¹³¹ And third, the Sub-Commission on the Promotion and Protection of Human Rights adopted a resolution on “Intellectual Property Rights and Human Rights.”¹³²

These positions found support in the Doha Declaration on the TRIPS Agreement and Public Health, adopted by the World Trade Organization (WTO).¹³³ In an unusually direct statement emanating from WTO,

127. See Beryl Leach, Joan E. Paluzzi, & Paula Munderi, U.N. MILLENNIUM PROJECT, PRESCRIPTION FOR HEALTHY DEVELOPMENT: INCREASING ACCESS TO MEDICINES 3 (2005); see also Alexandra Cameron et al., WHO, The World Medicines Situation, WHO/EMP/MIE/2011.2.1 (2011).

128. G.A. Res. 70/183, Global Health and Foreign Policy: Strengthening the Management of International Health Crises (Dec. 17, 2015); see also G.A. Res. 68/98, Global Health and Foreign Policy (Dec. 11, 2013) (noting “with particular concern that, for millions of people, the right to the enjoyment of the highest attainable standard of physical and mental health, including access to quality medicines, remains a distant goal.”).

129. See Michael A. Santoro, *Human Rights and Human Needs, Diverse Moral Principles Justifying Third World Access to Affordable HIV/AIDS Drugs*, 31 N.C. J. INT’L L. & COM. REG. 923 (2006); Lisa Forman, “Rights’ and Wrongs: What Utility for the Right to Health in Reforming Trade Rules on Medicines?,” 10 HEALTH & HUMAN RTS.: INT’L J. 37, 44 (2008); Marks, *Access to Essential Medicines*, supra note 127.

130. U.N. Human Rights Commission Res. 2001/33, U.N. Doc. E/CN.4/RES/2001/33 (Apr. 20, 2001).

131. U.N. Office of the High Commissioner of Human Rights (OHCHR), *The Impact of the Agreement on Trade-Related Aspects of Intellectual Property Rights on Human Right*, U.N. Doc. E/CN.4/Sub.2/2001/13 (June 27, 2001).

132. U.N. Human Rights Commission Res. 2001/21, U.N. Doc. E/CN.4/SUB.2/RES/2001/21 (Aug. 16, 2001).

133. World Trade Organization [WTO], Doha Ministerial 2001: Declaration on the TRIPS Agreement and Public Health, WTO Doc. WT/MIN(01)/DEC/ 2, 41 ILM 755 (2001) [hereinafter WTO, Declaration on TRIPS].

better known for highly technical and legally complex wording, the ministerial meeting declared: “The TRIPS agreement does not and should not prevent members from taking measures to protect public health . . . in particular to promote access to medicines for all.”¹³⁴ To avoid ambiguity, the Declaration continued, “In this connection, we reaffirm the right of WTO members to use, to the full, the provisions in the TRIPS Agreement, which provide flexibility for this purpose,” meaning that:

[E]ach member has the right to grant compulsory licences and the freedom to determine the grounds upon which such licences are granted . . . [and] the right to determine what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises, including those relating to HIV/AIDS, tuberculosis, malaria and other epidemics, can represent a national emergency or other circumstances of extreme urgency.¹³⁵

The rights expressed in the Doha Declaration are rights of states in accordance with their membership in WTO and their obligations under the TRIPS agreement.¹³⁶ They are, however, quite relevant to human rights, as expressed in CESCR’s General Comment Number 17:

States Parties should . . . ensure that their intellectual property regimes constitute no impediment of their ability to comply with their core obligations in relation to the right to health States thus have a duty to prevent unreasonably high license fees or royalties for access to essential medicines . . . [that] undermine the right . . . of large segments of the population to health.¹³⁷

In 2008 the Special Rapporteur on the Right to Health presented to the General Assembly his “Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines,” reiterating the requirements of the right to the highest attainable standard of health: “medicines are of good quality, safe and efficacious . . . [and] that existing medicines are accessible, [and] that much-needed new medicines are developed as soon as possible.”¹³⁸

134. See WTO, Declaration on TRIPS, *supra* note 134, ¶ 4.

135. *See id.* ¶ 5.

136. Marrakesh Agreement Establishing the World Trade Organization, annex 1C, pmbl., Apr. 15, 1994, 33 I.L.M. 1144, 1867 U.N.T.S. 154 (Agreement on Trade-Related Aspects of Intellectual Property Rights) (the parties recognize “the underlying public policy objectives of national systems for the protection of intellectual property, including developmental and technological objectives.”) [hereinafter TRIPS Agreement].

137. CESCR, *General Comment No. 17: The Right of Everyone to Benefit from the Protection of the Moral and Material Interests Resulting from Any Scientific, Literary or Artistic Production of Which He or She is the Author*, ¶ 35, U.N. Doc. E/C.12/GC/17 (Jan. 12, 2006).

138. Paul Hunt (Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health), *Rep. of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, Annex, Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines. Preamble ¶ p and ¶ 25 Commentary, U.N. Doc. A/63/263 (Aug. 11, 2008).

An article on these Guidelines offers an illustration of the use of access to medicines as part of the right to health and as a human right itself.¹³⁹ Suerie Moon, the Research Director of the Forum on Global Governance for Health at the Harvard Global Health Institute, assesses the guidelines for pharmaceuticals in the context of the related guidelines on business and human rights.¹⁴⁰ After noting that “[a]ccess to essential medicines has gradually come to be recognized as part of the human right to health,”¹⁴¹ she later refers to “the obligation of states to protect and fulfill the right to access to medicines.”¹⁴² In context these statements mean the same thing: governments have obligations to take measures to improve access to essential medicines in order to realize a human rights objective. The thrust of Moon’s article is that the guidelines developed and adopted in 2008 as the Guiding Principles on Business and Human Rights¹⁴³ focus on the missing element in the Guidelines for Pharmaceutical Companies, namely “remedying a pharmaceutical company’s actions to restrict access to medicines to a population.”¹⁴⁴

In 2009, The Human Rights Council addressed the issue in its Resolution 12/24, which recognized “that access to medicine is one of the fundamental elements in achieving progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,” and stressed “the responsibility of States to ensure access to all, without discrimination, of medicines, in particular essential medicines, that are affordable, safe, effective and of good quality.”¹⁴⁵ In a 2010 resolution, the Human Rights Council added that the right to health includes “access to . . . vaccines and other medical products, and to health-care facilities and services,”¹⁴⁶ and described as a “fact” the proposition quoted above from Resolution 12/24 regarding

139. See Suerie Moon, *Respecting The Right To Access to Medicines: Implications of the UN Guiding Principles on Business and Human Rights for the Pharmaceutical Industry*, 15 HEALTH & HUM. RTS. 32 (June 2013).

140. See *id.* at 32.

141. See *id.* at 33; see also LISA FORMAN & JILIAN C. KOHLER, *Introduction: Access to Medicine as a Human Right—What Does it Mean for Pharmaceutical Industry Responsibility?*, in ACCESS TO MEDICINES AS A HUMAN RIGHT: IMPLICATIONS FOR PHARMACEUTICAL INDUSTRY RESPONSIBILITY 3, 3 (2012), although not calling access a separate human right, nevertheless affirming that “Multiple declarations from international human rights bodies have reiterated that the right to health includes as a fundamental element the duty to provide access to medication, and that states hold a range of duties to respect, protect, and full access to affordable medicines.” *Id.*, at 9.

142. Moon, *supra* note 139, at 40.

143. See *infra* Table 1.

144. Moon, *supra* note 139, at 41.

145. Human Rights Council Res. 12/24, U.N. Doc. A/HRC/RES/12/24, at 2 (Oct. 12, 2009).

146. Human Rights Council Res. 15/22, U.N. Doc. A/HRC/RES/15/22, at 2 (Oct. 6, 2010).

access to medicine as a “fundamental element for achieving progressively” the right to health.¹⁴⁷

Civil society organizations have taken a step beyond merely reaffirming as “fact” that access is an element of the right to health; they referred to access as a human right, as the following three examples illustrate. From September 30 to October 2, 2005, some fifty academics and officials of governments, WHO, and various other international agencies met at the University of Montréal for a symposium entitled, “International Workshop on Human Rights and Access to Essential Medicines: The Way Forward.”¹⁴⁸ They drafted the Montréal Statement on the Human Right to Essential Medicines, which explains, “The human right to essential medicines requires that national health systems guarantee at all times that the population receive all essential medicines in adequate amounts, of assured quality, at the appropriate time and in the appropriate dosage.”¹⁴⁹ Other academic initiatives include Universities Allied for Essential Medicines, which adopted the Philadelphia Consensus Statement in October 2006.¹⁵⁰

A third example is Médecins Sans Frontières (MSF), which launched the MSF Access Campaign in 1999. In 2010, MSF representative Emanuel Tronc proclaimed to the Human Rights Council, “Let us be clear, access to essential medicines, including antiretroviral drugs for HIV/AIDS [is] a basic human right as articulated by a number of broadly ratified international and regional laws.”¹⁵¹ He called the provision of technical and financial support for HIV treatment and care “not an act of charity but rather an international legal obligation to fulfill the realization of the human right to health and access to medicines.”¹⁵²

WHO’s current position is that “[a]ccess to essential medicines as part of the right to the highest attainable standard of health (‘the right to health’) is well-founded in international law.”¹⁵³ Thus, access to essen-

147. See *id.* ¶ 4(k).

148. The background and a comment on the Montréal symposium appear in Thomas Pogge, *Montréal Statement on the Human Right to Essential Medicines*, 16 *Cambridge Q. Healthcare Ethics* 97, 105 (2007).

149. The text of the Montréal statement is reproduced at the end of Thomas Pogge, *id.* at 104-107.

150. See Ann Silversides, *Students, Scientists Push for Access to Drugs in Developing World*, 176 *CAN. MED. ASS’N J.* 914, 914 (Mar. 2007).

151. UN Human Rights Council, *Access to medicines in the context of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Transcript of MSF Statement to the Human Rights Council, Geneva, Oct. 11, 2010 [hereinafter UNHRC, *Access to Medicines Transcript*].

152. See UNHRC, *Access to Medicines Transcript*, *supra* note 151.

153. World Health Organization, *Access to Essential Medicines as Part of the Right to Health*, WORLD HEALTH ORGANIZATION (2016), http://www.who.int/medicines/areas/human_rights/en/ [https://perma.cc/2FHW-AAXY].

tial medicines has clearly become part of human rights discourse and is widely recognized as a basic component of the right to health, as well as the right to benefit from scientific progress.¹⁵⁴ For some, it is appropriate to underscore this normative expansion by referring to access to medicines as a human right itself.¹⁵⁵ Access to essential surgical care, as will be demonstrated in the next section, is at an earlier stage of recognition.¹⁵⁶

F. Essential and Emergency Surgery

In Kelly McQueen's study, "Essential Surgery: Integral to the Right to Health," she and her co-authors make the case "that essential surgical care should be considered an essential component of the basic human right to health."¹⁵⁷ Citing WHO, they note that eleven percent of the Global Burden of Disease can be treated with surgery.¹⁵⁸ They consider eleven percent a low estimate, but whatever the accurate figure, the burden of surgical disease is great enough to establish a presumption in favor of the issue being one of legitimate international concern for which priority attention as a matter of right would not unduly tax available resources and could be accommodated in a cost-effective way.¹⁵⁹

Moreover, essential and emergency surgery (EES), properly defined, may be inseparable from the rights to life and health, similar to the right to water.¹⁶⁰ It is undeniable that failure to recognize EES often results in denial of both of these rights.¹⁶¹ EES is also clearly feasible in clinical, economic, political, and legal terms, and can be monitored by the bodies responsible for interpreting and applying the right to health, for example, through shadow reports to the CESCR, as has been done for tobacco control.¹⁶²

154. Stephen P. Marks & Adriana L. Benedict, *Access to Medical Products, Vaccines, and Medical Technologies*, in *ADVANCING THE HUMAN RIGHT TO HEALTH* 305, 305 (José M. Zuniga, Stephen P. Marks, & Lawrence O. Gostin eds. 2013).

155. *Supra*, notes 149-153 and accompanying text.

156. *See infra* Part II.F.

157. K.A. Kelly McQueen, Doruk Ozgediz, Robert Riviello, Renee Y. Hsia, Sudha Jayaraman, Stephen R. Sullivan & John G. Meara, *Essential Surgery: Integral to the Right to Health*, 12 *HEALTH & HUM. RTS.* 137, 138 (2010).

158. *See id.* at 139.

159. *See id.* They explain in this regard, "Within the context of resource constraints, states must make decisions about how to use existing resources for the greatest benefit, and surgical care is viewed as competing with other types of treatment and prevention for limited resources . . . However, the World Health Organization and the Bellagio Group have begun to identify essential operations that significantly reduce the burden of disease at relatively low cost." *Id.* at 139.

160. *See* CESCR, *General Comment 15*, *supra* note 64 and accompanying text.

161. *See* McQueen et al., *supra* note 157, at 146-47.

162. *See* Dresler et al., *supra* note 123, at 208, for an example of such monitoring of tobacco control.

WHO has established the Global Initiative for Emergency and Essential Surgical Care (GIEESC) and the WHO Integrated Management for Emergency & Essential Surgical Care e-learning toolkit (CD).¹⁶³ In May 2015, the World Health Assembly adopted a resolution on “Strengthening Emergency and Essential Surgical Care and Anaesthesia in the context of Universal Health Coverage,” in which it called on Member States to develop and implement relevant policies “to be embedded in programmes and legislation based on current knowledge and considerations promoting the right to the enjoyment of the highest attainable standard of health.”¹⁶⁴ Drawing on the World Bank publication, *Essential Surgery*, a team of authors wrote in *The Lancet*:

Assurance of essential surgical services to everyone who needs them, when they need them, is deliverable partly through improved training in safe surgical care and technique, and partly through improved functioning of health systems—including better monitoring and evaluation, development of appropriate financing mechanisms, and promotion of equity, social justice, and human rights.¹⁶⁵

However, EES has not yet benefited from the equivalent of Human Rights Council Resolution 15/22 and the Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines.

With a proper characterization of surgery of the sort considered by the medical profession to be essential, recognition of EES as being integral to the right to health, and therefore an obligation of the state, can contribute to making it available, accessible, appropriate, and of quality as a matter of right, including for populations living in poverty or in humanitarian emergencies.¹⁶⁶

G. Newborn Screening for Cystic Fibrosis

The final example, among scores of health issues in which scholars and advocates have used a human rights framework, is the call for

163. *Integrated Management for Emergency and Essential Surgical Case (IMEESC) Toolkit*, WORLD HEALTH ORG. (2016), <http://www.who.int/surgery/publications/imeesc/en/> [<https://perma.cc/Q9V2-69KG>].

164. WHO, *Strengthening Emergency and Essential Surgical Case and Anaesthesia as a Component of Universal Health Coverage*, at 4, WHA68.15 (May 26, 2015).

165. Charles N. Mock, Peter Donkor, Atul Gawande, Dean T. Jamison, Margaret E. Kruk & Haile T. Debas, *Essential Surgery: Key Messages from Disease Control Priorities, 3rd Edition*, 385 LANCET 2209, 2217 (2015).

166. See U.N. ESC, CESCR *supra* note 38, ¶ 12. Poverty and humanitarian emergencies are mentioned here because they constitute circumstances when one might expect the condition of availability of resources to be difficult to meet. See ICESCR, *supra* note 14, Part II, ¶ 1. A significant insight of the normative expansion of the right to health to cover essential and emergency surgery (EES) is that availability of resources in most situations, including poverty and humanitarian emergencies, is not a determining limitation.

screening newborn babies (NBS) for cystic fibrosis.¹⁶⁷ Professor of Pediatrics and Population Health Sciences and expert on cystic fibrosis, Philip M. Farrell, explains:

[I]t is clearly the best interests and eminently fair for every child with cystic fibrosis [with certain mutations] to be diagnosed early, and since early diagnosis . . . to prevent unnecessarily suffering can only be achieved routinely through newborn screening, it may be argued that this is a human right.¹⁶⁸

He then enumerates four conditions that must be met before such screening can be considered a human right, relating to geographical location, existence of a NBS program, adequate follow-up, and adequate funding.¹⁶⁹ Drawing on the assessment of benefits and risks by the U.S. Centers for Disease Control and Prevention, he argues it should not be a human right “if more harm than good is likely,” or if the regional or resource conditions are not met.¹⁷⁰

This approach is convincing as a matter of public health: when the benefits of a procedure that avoids suffering clearly outweigh the risks, then the procedure should be performed.¹⁷¹ But as a matter of human rights, Farrell is forced to call NBS “at the most a relative human right.”¹⁷² More generally, this means that when a medical intervention is regarded as a necessary component of the “highest attainable standard of . . . health” and can be provided in accordance with a country’s “available resources,” then that procedure or intervention may be regarded as required by the state’s obligation to realize the right to health.¹⁷³ Declaring a “human right to NBS” is a misuse of terminology, however. Farrell’s intention seems to have been to draw on the human rights language to stress the value of NBS under certain conditions.¹⁷⁴ Unlike the authors cited above, who have advocated a human right to sexual and reproductive health, safe motherhood, tobacco control, essential medicines, and EES,¹⁷⁵ Farrell uses human rights language outside of the realm of international law.¹⁷⁶ There may be circumstances in which public health and medical knowledge and

167. See Philip M. Farrell, *Is Newborn Screening for Cystic Fibrosis a Basic Human Right?*, 7 J. CYSTIC FIBROSIS 262, 262 (2008).

168. See *id.* at 264.

169. See *id.*

170. See *id.*

171. See *id.*

172. See *id.* at 262.

173. See ICESCR, *supra* note 14, art. 2.

174. Farrell, *supra* note 168.

175. See *supra* Sections II.B–II.F.

176. Farrell, *supra* note 167. Neither “international” nor “law” appears anywhere in the article.

experience justify an intervention such as NBS, but this particular example, rather than contributing to the normative expansion of the right to health, seems to fall within the broad right to health obligations enumerated in ICESCR relating to “provision for the reduction of . . . infant mortality and for the healthy development of the child” and “[t]he prevention, treatment and control of . . . diseases.”¹⁷⁷

III: BOUNDING THE RIGHT TO HEALTH

Finally, to understand the normative expansion of the human right to health in the context of concern over excessive proliferation of human rights, it is useful, first, to clarify the difference between ordinary rights and human rights, and second, to apply these terminological nuances to the types of normative expansion observed with respect to the right to health.

A. Clarification of the Meaning of Rights

A semantic clarification may help avoid succumbing to the proliferation temptation.¹⁷⁸ In law, a “right” can mean any legally-protected interest, a valid claim or liberty, regardless of the social consequence of enforcement of the right on the wellbeing of persons other than the right-holder.¹⁷⁹ “Right” also refers to a moral, ethical, or legal principle considered necessary for justice or morality in society according to a wide range of theories of rights.¹⁸⁰

To avoid confusion, it is helpful to use the term “human right”—or one of its equivalents: “fundamental right,” “basic freedom,” “constitutional right”—to refer to a higher-order right, authoritatively defined and carrying the expectation that it has a peremptory character and thus prevails over other ordinary rights, and reflects the essential values of the society (national or international) that adopts it. In context, the qualifier “human” is often dropped when the meaning is clear, for example, when “the right to health” means “the human right to health.”¹⁸¹

177. See ICESCR, *supra* note 14, art. 12.2.

178. See Pizano, *supra* note 4 (identifying the proliferation temptation).

179. Examples might include the property right of a landlord to evict a tenant or the right of a business to earn profits. A broad definition is “[r]ights are entitlements (not) to perform certain actions, or (not) to be in certain states; or entitlements that others (not) perform certain actions or (not) be in certain states.” *Rights*, STAN. ENCYCLOPEDIA PHIL. (Sept. 9, 2015), <http://plato.stanford.edu/entries/rights/> (note that these meanings of “rights” are much broader than “human rights.”)

180. For a range of theories on this subject, see THEORIES OF RIGHTS (Jeremy Waldron ed., 1984).

181. Additional examples where “human” does not appear before “right” are the following Human Rights Council resolutions adopted on March 23, 2016: Human Rights Council Res. 31/7, U.N. Doc. A/HRC/RES/31/7 (Mar. 23, 2016) (“Rights of the child”); Human Rights Council Res.

Similarly, the “the right to tobacco control” means the right to benefit from “an effective tobacco control program”¹⁸² or “a right to be protected from tobacco” as part of the right to health.¹⁸³

The nuances of this terminology lead one to the conclusion that it is unwise to proclaim any desirable individual attribute or social arrangement a “human right,” without applying the necessary degree of “quality control” of the sort previously mentioned and thus limit normative expansion of new human rights to only the rare moral imperatives on which there is wide agreement.¹⁸⁴ At the same time, use of rights language for major components or elements may be justified if confirmed by a process leading to a valid non-binding instrument, such as the examples discussed: sexual and reproductive health, safe motherhood, tobacco control, essential medicines, and emergency surgery.¹⁸⁵ It is in this context that the normative expansion of the right to health may now be assessed.

B. Three Directions of Normative Expansion

This Article has illustrated the expansion of the normative content of the right to health in three directions. First, the epigrammatic formulas of the WHO Constitution and the UDHR have expanded the right through treaty norms, extending the definition and adding illustrative steps, as in Article 12 of the ICESCR and similar provisions in all the major U.N. and regional treaties.¹⁸⁶

Second, authoritative expert bodies have added non-binding amplifications through “essential elements,” “core minimum,” and “comparable priority” obligations and “attributes,” as defined by general comments, special procedures and OHCHR publications.¹⁸⁷ All of these amplifications take on legal significance as national judicial and administrative bodies and international monitoring procedures apply them through the growing case law in domestic courts and international litigation.¹⁸⁸

31/10, U.N. Doc. A/HRC/RES/31/10 (Mar. 23, 2016) (“The right to food”); Human Rights Council Res. 31/13, U.N. Doc. A/HRC/RES/31/13 (Mar. 23, 2016) (“Rights of persons belonging to national or ethnic, religious and linguistic minorities”); Human Rights Council Res. 31/15, U.N. Doc. A/HRC/RES/31/15 (Mar. 23, 2016) (“The right to work”). In each example, “human” could have been inserted, but is implied in all cases.

182. See Dresler & Marks, *supra* note 113, at 631.

183. See *id.* at 644.

184. See *supra* notes 54-55 and accompanying text.

185. See *supra* Part II.

186. See *infra* Table 1.

187. See *supra* notes 51-52 and accompanying text.

188. See Iain Byrne, *Enforcing the Right to Health: Innovative Lessons from Domestic Courts*, in REALIZING THE RIGHT TO HEALTH 525, 525, 520 n.29 (Andrew Clapham et al. eds.,

Third, civil society and academic initiatives have identified numerous priority health issues as human rights-relevant, sometimes calling them “new” or “derivative” human rights, or, more modestly, referring to them as “a right integral to the right to health.”¹⁸⁹ The Table below illustrates both the expanding normative content of the right to health in descending order of relative normativity, and the range of terms used to characterize the legal nature of new components of the right.

TABLE 1: EXPANDING HEALTH RIGHTS

Source	Legal nature	Component element of the right to health
<i>Core treaty and foundational provisions</i>		
WHO Constitution ¹⁹⁰	Treaty preamble	“The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”
UDHR Art. 25	GA Resolution	“[R]ight to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care”
ICESCR Art. 12(1)	Core treaty norm	“[T]he enjoyment of the highest attainable standard of physical and mental health.”
ICESCR Art. 12(2) [Similar elements in CEDAW Art. 12, CERD Art. 5 (e) (iv), European Social Charter Art. 11, African Charter Art. 16, Protocol of San Salvador Art. 10, and Arab Charter Art. 39.]	Treaty enumeration of illustrative “steps to be taken . . . to achieve the full realization of this right”	“(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” ¹⁹¹
<i>Authoritative non-binding interpretations</i>		
General Comment	Treaty body	“Functioning public health and health-care

2009); *see also* Oscar A. Cabrera & Ana S. Ayala, *Advancing the Right to Health Through Litigation*, in *ADVANCING THE HUMAN RIGHT TO HEALTH* 25, 25, 27 (José M. Zuniga et al., eds., 2013); Siri Gloppin & Mindy Jane Roseman, *Introduction: Can Litigation Bring Justice to Health?*, in *LITIGATING HEALTH RIGHTS: CAN COURTS BRING MORE JUSTICE TO HEALTH* 1, 3–4 (Alicia Ely Yamin & Siri Gloppen eds., 2011).

189. *See, e.g.*, CESCR, *General Comment 22*, *supra* note 87, ¶ 1; Dresler & Marks, *supra* note 113, at 629; McQueen et al., *supra* note 157, at 137.

190. *See* Constitution of the WHO, *supra* note 27, pmb1.

191. Many of these provisions are expanded in General Comment 14.

(GC) No. 14, paragraphs 11-12 ¹⁹²	interpretation of “essential elements” of the right to health	facilities, goods and services”; “safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs”; “Non-discrimination [in accessing] health facilities, goods and services”; “Physical accessibility [to] health facilities, goods and services . . . especially [for] vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS”; “affordability [of] payment for health-care services, as well as services related to the underlying determinants of health, . . . based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups”; “the right to seek, receive and impart information and ideas concerning health issues”; “All health facilities, goods and services must be respectful of medical ethics and culturally . . . scientifically and medically appropriate and of good quality”
General Comment No. 14, paragraph 43 ¹⁹³	Treaty body interpretation of “core minimum” of the right to health	“(1) [Non-discrimination in] access to health facilities, goods and services . . . especially for vulnerable or marginalized groups; (2) access to the minimum essential food which is sufficient, nutritionally adequate and safe, to ensure freedom from hunger to everyone; (3) . . . access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water; (4) . . . essential drugs, . . . (5) . . . equitable distribution of all health facilities, goods and services; (6) . . . national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population.”
General Comment No. 14, paragraph 44 ¹⁹⁴	Treaty body interpretation of “obligations of comparable priority” of the right to health	“(1) . . . [R]eproductive, maternal (pre-natal as well as post-natal) and child health care; (2) . . . immunization against the community’s major infectious diseases; (3) . . . measures to prevent, treat and control epidemic and endemic diseases; (4) . . .

192. See CESCR, *General Comment 14*, *supra* note 38, ¶ 11–12.

193. See *id.* ¶ 43.

194. See *id.* ¶ 44.

		education and access to information concerning the main health . . . ; (5) . . . appropriate training for health personnel, including education on health and human rights.”
Malhotra 2012 ¹⁹⁵	OHCHR definition of “attributes of the right to health”	“[S]exual and reproductive health,”; “child mortality and health care”; “natural and occupational environment”; “prevention, treatment and control of diseases”; and “accessibility to health facilities and essential medicines”
<i>Normative expansion defining specific rights</i>		
General Comment No. 15 ¹⁹⁶ and General Assembly Resolutions 64/292 ¹⁹⁷ and 70/169. ¹⁹⁸	GA resolution recognizing water as “a human right that is essential for the full enjoyment of life and all human rights”	“[T]he right to safe and clean drinking water and sanitation”; “the human right to sanitation entitles everyone, without discrimination, to have physical and affordable access to sanitation, in all spheres of life, that is safe, hygienic, secure, socially and culturally acceptable and that provides privacy and ensures dignity.”
General Comment No. 22 ¹⁹⁹	Treaty body interpretation of “the right to sexual and reproductive health”	“[T]he right to make free and responsible decisions and choices, free of violence, coercion and discrimination, regarding matters concerning one’s body and sexual and reproductive health. . . . unhindered access to a whole range of health facilities, goods, services and information, which ensure all people full enjoyment of the right to sexual and reproductive health.”
Cook 1998 ²⁰⁰ , Fathalla 2006 ²⁰¹	Academic proposal: “Human right(s) to safe motherhood”	Safe motherhood: “women’s rights to life, liberty and security of the person, health, maternity protection and non-discrimination and the ‘critical rights the observance of which would facilitate safe motherhood.’”
Marks & Dresler 2009, ²⁰² Daynard et al. 2012 ²⁰³	Academic proposal: “the emergence of an implied derivative human right to tobacco control”;	Tobacco control: obligations “to discourage the use of tobacco, drugs and other harmful substances”; “to discourage production, marketing and consumption of tobacco”; the “right to be free of secondhand smoke”

195. See OHCHR, *Human Rights Indicators*, *supra* note 52, at 31.

196. See CESCR, *General Comment 15*, *supra* note 64, ¶¶ 2–3.

197. G.A. Res. 64/292, *supra* note 66, ¶ 1.

198. G.A. Res. 70/169, *supra* note 74, ¶¶ 1–2.

199. See CESCR, *General Comment 22*, *supra* note 87, ¶ 5.

200. See Cook, *supra* note 104, 362–64.

201. Fathalla, *supra* note 107, at 409, 414–15, 417.

202. See Dresler & Marks, *supra* note 113, at 629.

203. Richard Daynard, *Allying Tobacco Control with Human Rights: Invited Commentary*, 21 TOBACCO CONTROL 213 (2012).

	“reconceptualization of tobacco control as a human rights issue and of human rights as a tobacco control issue”	
UN MDG Gap Task Force 2008, ²⁰⁴ Marks 2009, ²⁰⁵ Marks & Benedict 2013 ²⁰⁶	UN: “a prerequisite for realizing that right [to health]”; Academic proposal: “the human right to essential medicines as a derivative right within the broader right to . . . health.”	Essential medicines: “Access to medicines that are safe, effective, affordable and of good quality, in particular essential medicines, vaccines and other medical products, and to health-care facilities and services”; “that medicines are of good quality, safe and efficacious”; “that existing medicines are accessible, [and] that much-needed new medicines are developed as soon as possible.”
Kelly McQueen et al. 2010 ²⁰⁷	Academic proposal: “an essential component of the basic human right to health”	“Essential and emergency surgery,” “the delivery of essential surgical services,” “types of surgery that prevent significant morbidity and mortality at low cost”
Farrell 2008 ²⁰⁸	Academic proposal: “basic right to,” “a relative human right”	Newborn screening for cystic fibrosis

The list of concerns relevant to the realization of the right to health could be much longer, for example, by including the key elements of health systems that contribute to the realization of this right, as assessed in 2008 by an interdisciplinary team of scholars.²⁰⁹ They developed seventy-two indicators, arranged in fifteen groups,²¹⁰ which they applied

204. U.N. MDG Gap Task Force, *Millennium Development Goal 8: Delivering on the Global Partnership for Achieving the Millennium Development Goals*, at 42 (2008).

205. See Marks, *Access to Essential Medicines*, *supra* note 126, at 80.

206. See Marks & Benedict, *supra* note 154, at 305.

207. See McQueen et al., *supra* note 157, at 138, 143–44, 146–47.

208. See Farrell, *supra* note 167, at 262, 264.

209. Gunilla Backman, Paul Hunt, Rajat Khosha, Camila Jaramillo-Strouss, Belachew Mekuria Fikre, Caroline Rumble, David Pevalin, David Acurio Páez, Mónica Armijos Pineda, Ariel Frisancho, Duniska Tarco, Mitra Motlagh, Dana Farcasanu, & Cristian Vladescu, *Health Systems and the Right to Health: An Assessment of 194 Countries*, 372 LANCET 2047, 2047–85 (2008).

210. The fifteen groups are: recognition of the right, non-discrimination, health information,

to the health systems of 194 countries.²¹¹ These indicators should be distinguished from the component elements of the right to health listed in Table 1, because they are tools of assessment for monitoring and evaluating the processes and results of efforts by States Parties to fulfill their obligations with respect to this right.²¹² These indicators are essential for gauging progress in advancing the right to health, including with respect to the areas of normative expansion, but are not components of that expansion, and therefore do not contribute to the proliferation of rights. It is rather among the broader definitions of the right and its components that care must be taken to avoid inflation and dilution of human rights, as discussed in the next Section.

C. Drawing the Line Between the Right to Health, Rights Integral to that Right, and Steps to Realize that Right

The seven right-to-health issues discussed above—water and sanitation, sexual and reproductive health, safe motherhood, tobacco control, access to medicines, essential and emergency surgery, and cystic fibrosis screening—exemplify the variety of framings of public health concerns in human rights language.²¹³ Dubbing them “new human rights” might enhance the emotional appeal in the context of advocacy, but is inaccurate from a legal perspective and would lend support to those who warn against proliferation, inflation, or dilution of human rights.²¹⁴ As human rights professor Hurst Hannum said, “[A]ttempting to expand the scope of human rights too quickly plays into the hands of those who exalt stability above all else, and consolidating rights within societies remains a formidable task.”²¹⁵

Sexual and reproductive health, safe motherhood, tobacco control, access to medicines, and essential and emergency surgery are treated above as clarifying the normative content of the right to health rather than as new rights.²¹⁶ The rights to water and sanitation—considered in

national health plan, participation, underlying determinants of health, access to health services, medicines, health promotion, health workers, national financing, international assistance and cooperation, additional safeguards, awareness-raising, and monitoring/assessment/accountability/redress. *See id.* at 2057–58.

211. *See id.* at 2062–71.

212. *See id.* at 2081.

213. *See supra* Part II.

214. Numerous international legal scholars have warned against the unbridled proliferation of human rights. *See, e.g.*, ERIC A. POSNER, *THE TWILIGHT OF HUMAN RIGHTS LAW* (2014); Michael Ignatieff, *Human Rights as Idolatry*, in *HUMAN RIGHTS AS POLITICS AND IDOLATRY* (Amy Gutman ed., 2003); ALLEN BUCHANAN, *THE HEART OF HUMAN RIGHTS* (2013); Hurst Hannum, *Reinvigorating Human Rights for the Twenty-first Century*, 16 *HUM. RTS. L. REV.* (2016) 409–451.

215. *See* Hannum, *supra* note 214, at 450.

216. *See supra*, Part II, Section B-F.

a 2003 General Comment as derivative of the rights to an adequate standard of living and the right to health—attained the status of a stand-alone human rights through formal recognition in General Assembly resolutions of 2010 and 2015.²¹⁷ The normative status of the rights to water and sanitation are similar to the six other components in that they are not treaty-based, but differ from them insofar as they have crossed the threshold of G.A. Resolution 41/120, and have emerged from their derivative status to become autonomous human rights, albeit in the limbo of the non-binding instruments discussed above.²¹⁸ This normative expansion adds to the list of internationally recognized human rights, without necessarily going too far in the direction of proliferation.

In contrast, it was not a useful effort to propose screening for cystic fibrosis as a human right to thus expand the normative content of the right to health.²¹⁹ Table 1 ranks the normative expansion in descending order of relative normativity with NBS ranked last, having no meaningful normative value compared to the other rights examined.²²⁰ More accurately, NBS is an appropriate intervention under the right conditions.²²¹

It was particularly unhelpful to triumphantly proclaim abortion a human right.²²² It is more accurate to say that safe abortions are part of the recognized right to sexual and reproductive health integral to the right to health, and that human rights have been used to provide a remedy to women denied that right.²²³ A strong moral claim can be made that safe abortions must be available as a matter of right, which is not the same as saying abortion is a human right in international law. At the level of moral rights, many also affirm that every child has a human right to life from the moment of conception or at a particular stage before birth.²²⁴ Abortion thus offers an excellent illustration of the difference between moral and legal rights.

As noted above, the Beijing Declaration and Platform for Action reaffirmed “the right of all women to control all aspects of their health, in

217. See G.A. Res 64/292, *supra* note 66, at 2; G.A. Res. 70/169, *supra* note 74, at 4.

218. See Shelton, *supra* note 23, at 159–63; Chinkin, *supra* note 72, at 865; Schwebel, *supra* note 72, at 301–02 and accompanying text.

219. See *supra* Part II.F.

220. See *supra* Table 1.

221. See Farrell, *supra* note 167, at 262. It should be noted that that the author of the article proposing this right is an expert in cystic fibrosis writing in a journal specializing in cystic fibrosis, with no claims to address international law.

222. See Grimes, *supra* note 93.

223. See, e.g., Huaman v. Peru, *supra* note 95, at ¶¶ 2.1–2.6, 7–8.

224. Bertha Alvarez Manninen, *Revisiting the Argument From Fetal Potential*, 2(7) PHIL., ETHICS, & HUMAN. MED. 1, 1 (2007); Burleigh T. Wilkins, *Does the Fetus Have a Right to Life?*, 24(1) J. SOC. PHIL. 123, 123 (1993).

particular their own fertility.”²²⁵ At the national level, there is a “right to an abortion” for about one-third of countries which allow abortion by choice, and in ninety-seven-percent of countries to save the life of the woman.²²⁶ That is not, however, the same as legally or morally affirming that there is a human right to abortion, unless that right attains the level of a constitutional right, or a similar provision that would make it extremely difficult to abolish by mere legislative enactment.

Nor is it accurate, as previously explained, to affirm that the United Nations has declared abortion as such a human right.²²⁷ The language articulating a woman’s right to control her fertility comes close to affirming such a right, and U.N. policy is moving in that direction.²²⁸

The first treaty to affirm such a right under defined circumstances is the Maputo Protocol on the Rights of Women in Africa, according to which “States Parties shall take all appropriate measures to: ... c) protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.”²²⁹ However, this Protocol is open only the members of the African Union and the United Nations has no similar instrument nor has it declared abortion as such a human right.

Between accurate claim that water and sanitation are (newly) recognized human rights, and the misleading and inaccurate claim that NBS is a relative human right or that abortion is a United Nations recognized human right, lie the five high priority issues of sexual and reproductive health, safe motherhood, access to essential medicines, essential surgery, and tobacco control, addressed primarily through non-binding in-

225. See Fourth World Conference on Women, *supra* note 79, Annex I at ¶ 17 and Annex II at ¶ 92.

226. U.N. Dep’t of Econ. & Soc. Affairs, Population Division, *Abortion Policies and Reproductive Health around the World* 3 (2014), <http://www.un.org/en/development/desa/population/publications/pdf/policy/AbortionPoliciesReproductiveHealth.pdf> [<https://perma.cc/E4FS-ZSTM>].

227. See *supra* Part II.B.

228. OHCHR summarizes that situation as follows:

International human rights bodies have characterized laws generally criminalizing abortion as discriminatory and a barrier to women’s access to health care. They have recommended that States remove all punitive provisions for women who have undergone abortion. These bodies have also requested that States permit abortion in certain cases. Treaty body jurisprudence has clearly indicated that denying women access to abortion where there is a threat to the woman’s life or health, or where the pregnancy is the result of rape or incest violates the rights to health, privacy and, in certain cases, to be free from cruel, inhumane and degrading treatment.

OHCHR, *Information Series on Sexual and Reproductive Health and Rights: Abortion*, http://www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO_Abortion_WEB.pdf (Citations omitted).

229. Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, Article 14.

struments, such as general comments and other authorized expert views. Claiming a human right to each of these priority issues avoids antagonizing the anti-proliferation crowd as long as doing so is understood to mean that such public health goals are integral components of the right to health.

As non-binding instruments, resolutions and authorized expert views rank high on the scale of relative normativity.²³⁰ In light of the growing number of consistent non-binding instruments, it is accurate to refer to a human right to access to essential medicines, for example, when that is clearly understood to be part of the human right to health. A similar terminology is appropriate for the human rights to sexual and reproductive health, safe motherhood, tobacco control, essential and emergency surgery, and other essential elements of the right to health.

When they are included among the core minimum, and therefore not subject to progressive realization, the legal consequences of such non-binding instruments are far-reaching in that lack of resources does not, in principle, excuse a state from failure “to ensure the satisfaction of, at the very least, minimum essential levels of” the nine core and comparable priority obligations enumerated in General Comment Number 14.²³¹ The CESCR distinguishes “the inability from the unwillingness of a State [P]arty to comply with its obligations under [A]rticle 12,”²³² and clearly puts States Parties on notice of the consequences:

A State which is unwilling to use the maximum of its available resources for the realization of the right to health is in violation of its obligations under article 12. If resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above. It should be stressed, however, that a State [P]arty cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations set out in [P]aragraph 43 . . . which are nonderogable.²³³

Further, governments should be held accountable through advocacy and national and international legal processes for failure to comply with such obligations,²³⁴ because, although these high priority issues are not autonomous rights to which governments have committed by treaty, they are nonetheless components of the right to health elucidated by authoritative non-judicial bodies.²³⁵

230. *See supra* Table 1.

231. These obligations appear in *supra* Table 1.

232. *See* CESCR, *General Comment 14*, *supra* note 38, ¶ 47.

233. *See id.*

234. *See id.* ¶ 59–62.

235. *See supra*, notes 19–22 and accompanying text.

In this way, these public health imperatives join the attributes, core minimum, essential elements, steps to be taken, and core treaty norms in defining the expanding content of the right to health, while setting boundaries as to what is properly called a “new” or “derivative” human right.

CONCLUSION: FINAL OBSERVATIONS ON THE ONTOLOGY OF HUMAN RIGHTS

As stated in the opening of this Article, this rich harvest of the expanding normative content of the right to health poses a challenge in terms of both the ontology and epistemology of human rights norms on the one hand, and the practical utility of inserting human rights norms in documents that purport to carry legal weight on the other.²³⁶

Philosopher and economist, Amartya Sen, affirms that human rights are moral rights grounded in ethics:

The invoking of human rights tends to come mostly from those who are concerned with changing the world rather than interpreting it The colossal appeal of the idea of human rights [has provided comfort to those suffering] intense oppression or great misery, without having to wait for the theoretical air to clear.²³⁷

Sen adds, “Human rights can be seen as primarily ethical demands Like other ethical claims that demand acceptance, there is an implicit presumption in making pronouncements on human rights that the underlying ethical claims will survive open and informed scrutiny.”²³⁸ Whether such “open and informed scrutiny” includes the legal process is critical to the core question of this Article. In Sen’s view, “Even though human rights can, and often do, inspire legislation, this is a further fact, rather than an constitutive characteristic of human rights,”²³⁹ implying an inherent value of the concept of human rights, independent of what is established in law. Writing on the right to health, he describes the “idea of human rights” as being “more as a ‘parent of law’ in guiding legislation” than a “child of law” as Bentham would have it, since, as stated above, human rights motivate action.²⁴⁰ Therefore, “In seeing health as a human right, there is a call to action now to advance people’s health in the same way that the 18th-century activists fought for freedom and liberty.”²⁴¹

236. *See supra* Introduction.

237. Amartya Sen, *Elements of a Theory of Human Rights*, 32 PHIL. & PUB. AFFAIRS, 315, 317 (Nov. 4, 2004).

238. *See id.* at 320.

239. *See id.* at 319.

240. Amartya Sen, *Why and How is Health A Human Right?*, 372 LANCET 2010, 2010 (Dec. 2008).

241. *See id.*

From the ontological perspective, British philosopher and academic, Jonathan Wolff, takes a radically different approach to human rights as legal rights. It can be argued, according to Wolff, that there cannot be a human right to health because “the content of the human right to health cannot be coherently specified.”²⁴² Wolff questions whether General Comment Number 14 has provided adequate specificity and argues that “to some degree it has avoided the main question,” namely, “when is failure to supply medical care or other determinants of health nevertheless not a human rights failure.”²⁴³ Wolff worries that courts would need to determine “when is it acceptable *not* to supply something that would be likely to improve health.”²⁴⁴ However, he overlooks that fact that in major cases courts have made such determinations (despite having analyzed such case law elsewhere).²⁴⁵

For example, in *Soobramoney v. Minister of Health*, the South African Constitutional Court let stand a government denial of dialysis for a man with failing kidneys, because the constitutionally-mandated right to emergency medical treatment did not require the state to provide it.²⁴⁶ Referring to the constitutional provisions on health and similar rights, the court stated:

What is apparent from these provisions is that the obligations imposed on the state . . . are dependent upon the resources available for such purposes, and that the corresponding rights themselves are limited by reason of the lack of resources. Given this lack of resources and the significant demands on them . . . an unqualified obligation to meet these needs would not presently be capable of being fulfilled.²⁴⁷

The court further reasoned that:

[Providing dialysis] would also have the consequence of [prioritizing] the treatment of terminal illnesses over other forms of medical care and would reduce the resources available to the state for purposes such as preventative health care and medical treatment for persons suffering from illnesses or bodily infirmities which are not life threatening.²⁴⁸

Justice Sachs eloquently added, “In all the open and democratic socie-

242. Jonathan Wolff, *The Content of the Human Rights to Health*, in PHILOSOPHICAL FOUNDATIONS OF HUMAN RIGHTS 491, 491–93 (Rowan Cruft, S. Matthew Liao, & Massimo Renzo eds., 2015).

243. *See id.* at 492.

244. *See id.* at 493 (emphasis added).

245. *See, e.g.*, Jonathan Wolff, *The Human Right to Health*, in GLOBAL HEALTH AND GLOBAL HEALTH ETHICS 108–18 (Solomon Benatar & Gillian Brock eds., 2011).

246. *Soobramoney v. Minister of Health (Kwazulu-Natal)*, 1998 (1) SA 765 (CC) at ¶ 36 (S. Afr.).

247. *See id.* ¶ 11.

248. *See id.* ¶ 19.

ties based upon dignity, freedom and equality with which I am familiar, the rationing of access to life-prolonging resources is regarded as integral to, rather than incompatible with, a human rights approach to health care.”²⁴⁹

Thus, the right to health, as defined internationally, does allow a “failure to supply medical care” due to resource constraints not to be “a human rights failure.”²⁵⁰ Wolff is correct to warn that, “Used the wrong way a human right to health approach can prioritize the claims of the powerful, vocal, troublesome and well organized, leaving the most vulnerable unprotected.”²⁵¹ The example of the use of health rights litigation in South and Central America suggests that the courts might distort health resource priority setting and national health planning.²⁵²

Litigation, with its attendant distortions of priorities, is far from the only means of holding governments accountable for their treaty obligations, however. Other means less likely to distort priorities include: first, the review of states’ reports under Part IV of the ICESCR; second, the Universal Periodic Review (UPR); third, reports of special rapporteurs, especially on the right to health; and fourth, cases brought under the Optional Protocol to the ICESCR.²⁵³

From a legal perspective, a human right to health exists only if it is established by law, either national or international, and is limited to the content set out in the law. Thus, the normative content would be limited, for example, to the specific text of Article 12 of the ICESCR, in light of the nature of the obligations as set out in Article 2, and similar provisions of other treaties. But the concept of relative normativity justifies expanding the normative content through non-binding instruments that constitute a meaningful and consequential form of “open and informed scrutiny.”²⁵⁴

Whether international human rights law is constitutive or declarative of human rights, some form of quality control is necessary. The process has been reasonable and coherent so far, when in the hands of authoritative experts and political bodies, primarily the CESCR, the Special rapporteur, and the Human Rights Council. Proposals emanating from

249. *See id.* ¶ 52 (Sachs, J., concurring).

250. *See* Wolff, *supra* note 242 at 492.

251. *See* Wolff, *supra* note 245 at 116.

252. *See* Wolff, *supra* note 242 at 497–98.

253. The full range of monitoring mechanisms of the right to health is reviewed in: José M. Zuniga, Stephen P. Marks & Lawrence O. Gostin, *ADVANCING THE HUMAN RIGHT TO HEALTH* (2013); JOHN TOBIN, *THE RIGHT TO HEALTH IN INTERNATIONAL LAW* (2012); *Realizing the Right to Health*, 3 *SWISS HUM. RIGHTS BOOK* (Andrew Clapham, Mary Robinson, Claire Mahon, & Scott Jerbi eds., 2009);

254. *See* Sen, *supra* note 237 at 320.

speculations of academics and advocacy of “those who are concerned with changing the world rather than interpreting it”²⁵⁵ constitute a desirable source of new ideas and formulation of proposals for further normative expansion. One of the most encouraging features of the human rights system as it has evolved in the past decades is that genuinely expert treaty bodies and special procedures are able to interact meaningfully with both academic and advocacy constituencies, filtering the proposed further normative expansion through a functioning quality control mechanism. The result is that the current normative expansion from the original thirty words in the WHO Constitution and twenty-three in the UDHR is now vast but, thanks to effective quality control, not unwieldy.

Nevertheless, the epistemological issue this Article seeks to address in conclusion is at what point formal normative pronouncements in the health field cease to articulate a human right to health and become the enumeration of practical steps necessary to realize some feature of the right to health. Regarding these steps, Wolff raises the issue that “when specified the human right to health leads to unattractive, or at least sub-optimal health practices.”²⁵⁶ He also takes issue with the phrase “highest attainable standard of health,” as used by the drafters of the WHO constitution and Article 12 of the ICESCR, and believes “fully adequate” might have been better.²⁵⁷ His objection seems to derive from the impression that “highest attainable standard” allows rich countries that “exceed many of their human right to health obligations” to withdraw some services without violating the human right to health.²⁵⁸ The “highest attainable standard,” however, seems to offer adequate clarity to deter retrogression in rich countries; if services exceed those required to meet the obligations of Article 12, it is a political matter for the regulatory and legislative authorities of the rich countries to maintain or increase the services in question. Further, the reverse can be argued: holding poor countries to the “fully adequate” standard reduces the flexibility of progressive realization, and could require South Africa, for example, to provide dialysis to Soobramoney and persons in similar situations, thereby drastically decreasing its ability to provide primary care.²⁵⁹

As noted above, Wolff is correct that litigating the human right to health can result in distortions of equity in the health system. Replacing “highest available” with “fully adequate” will not solve that problem.

255. *See id.*

256. *See id.* at 491.

257. *See id.* at 501.

258. *See id.*

259. *See supra*, note 246 and accompanying text.

The normative expansion of the right to health would be problematic if it were designed exclusively or primarily to provide grounds for litigation. Whether the “human right to health leads to unattractive, or at least sub-optimal health practices” matters more than deterring retrogressive practices in rich countries or inequitable consequences from litigation.

In fact, the ICESCR in general and the right to health provision in particular are designed as instruments for promotion of good practices, rather than as bases for litigation. While it is true that General Comment Number 14 refers to and gives examples of violations,²⁶⁰ its thrust is to draw “on the Committee’s experience in examining States [P]arties’ reports over many years” and clarify obligations “[w]ith a view to assisting States [P]arties’ implementation of the Covenant and the fulfillment of their reporting obligations.”²⁶¹

From this perspective, monitoring through the four mechanisms mentioned above (reporting under the ICESCR, UPR, reports by special rapporteurs, and complaints procedures)²⁶² involves dialogue with governments, more than litigation, to both draw attention to shortcomings and to propose concrete measures of improvement.²⁶³ The reporting procedure allows the CESCR at each session to issue concluding observations on a handful of countries—approximately seventeen in 2016²⁶⁴—containing detailed observations and recommendations on a wide range of right to health issues.²⁶⁵ The UPR allows civil society, independent national human rights institutions, U.N. bodies, and govern-

260. See CESCR, *General Comment 14*, *supra* note 38, ¶¶ 46–52. On violations, the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights were adopted by a group of experts in 1997 to provide guidance to all who are concerned with monitoring and adjudication these rights. Cees Flinterman, Scott Leckie, & Victor Dankwa, *Commentary to the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights*, 20 HUMAN RIGHTS QUARTERLY 705, 705-30 (1998).

261. See CESCR, *General Comment 14*, *supra* note 38 at ¶ 6.

262. See Wolff *supra*, note 242 at 497-98; see also *supra* note 253 and accompanying text.

263. Jane Connors & Markus Schmits, *United Nations*, in INTERNATIONAL HUMAN RIGHTS LAW 359, 376-84 (Daniel Moeckli, Sangeeta Shah & Sandesh Sivakumaran, 2d ed., 2014).

264. See *2016 Expected Date of Consideration*, OHCHR, http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/MasterCalendar.aspx?Type=Session&Lang=En [https://perma.cc/NN9K-MS8C] (last visited Aug. 15, 2016).

265. A random example would be the concluding observations on the right to health in Italy, in which the CESCR expressed its concern, among other issues, about regional disparities in access to basic health-care services, the inadequate measures taken by the State Party to address such disparities, budget cuts, increased fees for health-care services, reinstitutionalization of dependent persons and persons with intellectual and psychosocial disabilities, and unsafe abortions, and recommended effective measures to ensure equal access to basic health-care services, alternative family- and community-based care systems for dependent persons and persons with intellectual and psychosocial disabilities, access to abortion services, combat obesity (particularly among children), and higher taxes on junk foods and sweet beverages. CESCR, Concluding observations on the fifth periodic report of Italy, ¶¶ 46–51, U.N. Doc. E/C.12/ITA/CO/5 (Oct. 28, 2015).

ments to make recommendations regarding reports required of all governments—including those like the United States that have not ratified the ICESCR—on their efforts to improve human rights, including the right to health.²⁶⁶ The Special Rapporteur (SR) issues thematic reports which allow for further proposals for normative expansion of the right to health, such as the Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines.²⁶⁷ The SR also addresses specific right to health problems through country visits—some twenty-one so far—which result in detailed reports identifying areas for improvement.²⁶⁸ Finally, the SR receives and responds to individual complaints.²⁶⁹ These complaints, like those brought to the CESCR under the Optional Protocol²⁷⁰ are a form of quasi-litigation; however, both the CESCR and the SR do not function as a judicial body but work to improve the situation and seek a dialogue with the government. While they can draw the attention of governments to violations, their case law is not as likely to cause the sorts of distortions in priority-setting and equity that arises in national litigation, as described above.²⁷¹

Of course, independent researchers and academics also contribute to translating the expanding normative content of the right to health into recommendations for practical action. An excellent example is the study previously referred to and published in the *Lancet* in 2008, which makes five recommendations to WHO and the Office of the High Commissioner for Human Rights, five to other U.N. specialized agencies, fourteen to national governments, six to national and international civil society, four to research institutions, and four to donors.²⁷²

These practical examples of international settings where the right to health has been defined, refined, expanded, and monitored have implications for the grounding of human rights. The ethical basis of human rights has been defined using concepts such as human flourishing, dig-

266. For example, six recommendations on the right to health were addressed to the United States in 2015. U.N. HRC, Rep. of the Working Group on the Universal Periodic Review, United States of America ¶¶ 176.313–176.318, U.N. Doc. A/HRC/30/12 (July 20, 2015).

267. See Hunt, *supra* note 138, annex, at 15.

268. *Country Visits*, OHCHR, <http://www.ohchr.org/EN/Issues/Health/Pages/CountryVisits.aspx> [<https://perma.cc/SK9M-J2B6>] (last accessed Aug. 14, 2016).

269. Human Rights Council resolution 2002/31 of April 22, 2002, authorizes the SR to respond to allegations of violations of the right to health by writing to the Government concerned, inviting comment on the allegation. After considering the response, the SR can call on the government to take all steps necessary to redress the alleged violation.

See <http://www.ohchr.org/EN/Issues/Health/Pages/IndividualComplaints.aspx>

270 Optional Protocol to the International Covenant on Economic, Social and Cultural Rights (Dec. 10, 2008), G.A. Res. 63/117.

271. See *supra* note 252 and accompanying text.

272. See Backman et al., *supra* note 209, Panel 12, at 2078–79.

nity, duties to family and society, natural rights, individual freedom, and social justice against exploitation based on sex, class, or caste.²⁷³ Whether human rights discourse is essentially ethical and philosophical or legal and political is a matter of dispute.²⁷⁴ This Article contends that it is both. Human rights are conceived through ethical reasoning drawing on experience, beliefs, and theories of justice but they become part of the global normative order through the norm-creating process of law.²⁷⁵ This Article assumes that the most relevant “open and informed scrutiny” (to use Sen’s expression) is this norm-creating process of law, which allows for the distillation of those moral precepts—and public health imperatives—to rise to the level of supreme values of society through a legislative process resulting in constitutional and international treaty human rights norms. The normative expansion of the human right to health has also benefited from expert and civil society inputs, mitigated through a mechanism of quality control and, as a result, has influenced the policies and practices of states, and eventually improved the lives of human beings.

273. See, e.g., James Nickel, *Human Rights*, STAN. ENCYCLOPEDIA PHIL. (Edward N. Zalta, ed., Winter 2014), <http://plato.stanford.edu/archives/win2014/entries/rights-human/> [<https://perma.cc/6ANR-AMSW>].

274. See *supra* notes 237-241 and accompanying text.

275. See Charles R. Beitz, *THE IDEA OF HUMAN RIGHTS* 209–212 (2009) (on human rights and the global normative order).