

THE RIGHT TO HEALTH: A RIGHT ON THE RISE?

Richard Baker and Vanessa Taylor

INTRODUCTION

Some scholars say Aristotle espoused the right to health in *Politics*, his treatise on government. Others take the view that translating his language in this way imposes the concept onto a different time and culture.¹ Whatever the arguments around Aristotle's views, the right to health developed into a fundamental human right expressed in international documents of last century.

The right to health issue has attracted much attention recently, particularly, its most practical aspect, the right to health care. In July this year, *The New England Journal of Medicine* published an article by Keren Ladin and Douglas W. Hanto criticising judicial interference with the rationing process for lung transplants in the United States of America.²

In this case, a ten year old child was wait-listed for a lung transplant due to cystic fibrosis. Through her treating doctors, she appealed to be an exception to the Organ Procurement and Transplantation Network's policy banning children under the age of 12 from receiving organs from older donors. When the appeal was refused, the child's family claimed discrimination and obtained a Federal Court injunction ordering the Network to allow her access to the pool of adult donors. The injunction was granted on the grounds that the allocation policy was "arbitrary and capricious". Ladin and Hanto believe that such cases "may open the floodgates to litigation from patients seeking to improve their chances of obtaining organs". They acknowledge that this and similar cases "questioned potential disadvantaging of children and the procedural fairness in lung allocation", but are concerned that "legal appeals exacerbate inequities and undercut public trust in the organ-transplantation system".

The family's media campaign and internet petition led to much public debate over the issues the case raised. There is no right to health in the US Constitution.

¹ Pellegrino, Edmund D, and staff at the National Reference Center for Bioethics Literature, *Aristotle and the Right to Health Care: A Cautionary Tale*, Appendix to Scope Note, (2008) http://bioethics.georgetown.edu/publications/scopenotes/sn20_appendix.pdf [accessed 19 July 2013].

² Ladin, Keren and Douglas W. Hanto, "Rationing Lung Transplants – Procedural Fairness in Allocation and Appeals" (2013) DOI: 10.1056/NEJMp1307792, *The New England Journal of Medicine* <http://www.nejm.org/doi/full/10.1056/NEJMp1307792> [accessed 25th July 2013].

While the largest nation by health care expenditure, the US, deals with uncertainties around health rights, the largest nation by population is not faring much better. In the People's Republic of China, as scholar Lijing Cao reveals:

Unfortunately, it is generally accepted that no right to health or health care exists under China's Constitution. The establishment of a legal mechanism regarding the right to health care is still in progress, and the legal framework to address health inequity problems remains limited in scope.³

With these two giants of countries dragging their feet, it is timely to examine the right to health through international instruments, national constitutions and the divergent case law from countries in which the right to health has been litigated.

WHAT IS HEALTH?

Out of the horrors of World War II came the formation of the United Nations. Its agency, the World Health Organization (WHO) came into existence in 1948.⁴ Since that time, WHO has set the norms and standards of global health.

During the drafting of WHO's constitution in 1946, many founding members were against the inclusion of a definition of health. But three founders formed "a pleasant little group": Dr Szeming Sze of China, Dr Georgio Bermann of Argentina and Dr Brock Chisholm of Canada, a psychiatrist who became the inaugural Director-General of WHO. Together they set about devising a definition that incorporated mental health and preventative health care.⁵

The trio arrived at a one-sentence definition:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.⁶

³ Cao, Lijing "The Prospect for health Care in China" (2012) A thesis submitted in conformity with the requirements for the degree of Master of Laws Graduate Department of the Faculty of Law University of Toronto

https://tspace.library.utoronto.ca/bitstream/1807/33715/1/Cao_Lijing_201211_LLM_thesis.pdf [accessed 28 July 2013].

⁴ Details with various links to key documents may be found at <http://www.who.int/about/history/en/index.html> [accessed 3 September 2013].

⁵ Sze, Szeming, 'Forum Interview with Szeming Sze', *World Health Forum*, Vol. 9, 1988, 1988; 9(1): 29-34, [http://whqlibdoc.who.int/analytics/WHForum_1988_9\(1\)_29-34.pdf](http://whqlibdoc.who.int/analytics/WHForum_1988_9(1)_29-34.pdf) [accessed 19 July 2013].

⁶ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

This definition leads the preamble of the WHO Constitution, which entered into force in April 1948.⁷

Ten months later, the General Assembly of the United Nations adopted its seminal document, the *Universal Declaration of Human Rights (UDHR)*.⁸ Article 25(1) of the Declaration states:

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

In 1976, after ten years' gestation, the UN's *International Covenant on Economic, Social and Cultural Rights*⁹ (*ICESCR*) entered into force. The right to health is confirmed and illustrated in Article 12:

The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

- a. The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
- b. The improvement of all aspects of environmental and industrial hygiene;
- c. The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
- d. The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

The committee responsible for interpreting the *ICESCR*, the Committee on Economic, Social and Cultural Rights (CESCR), issued *General Comment No. 14* in 2000 to provide

⁷ The document is available at <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf> [accessed 3 September 2013].

⁸ *Universal Declaration of Human Rights*, GA Res 217A (III) UN Doc A/810 (1948). In September 1948, the first draft of the Universal Declaration of Human Rights was proposed. Over fifty Member States participated in the final drafting. The General Assembly adopted the Declaration by its resolution 217 A (III) of 10 December 1948. There were no dissenters, but eight nations abstained from the vote (six Soviet Bloc countries, South Africa, and Saudi Arabia). <http://www.un.org/en/documents/udhr/history.shtml> [accessed 20 July 2013].

⁹ *International Covenant on Economic, Social and Cultural Rights (ICESCR)*, 3 January 1976, 993 UNTS 3 (2013) J. JURIS 277

guidance on the substantive issues arising in the implementation of Article 12.¹⁰ This General Comment reiterated the right to the highest attainable standard of health, but acknowledged that Member States cannot protect individuals from every cause of ill health.¹¹ Therefore, the right to health “is not to be understood as a right to be *healthy*”.¹²

ELEMENTS OF THE RIGHT

How far the abstract legal terms of international conventions and documents can be translated into clinical and scientific practice will depend on how the word “health” is defined.

Some members of the scientific community believe the definition in the WHO constitution is static and outdated:

Health! – something we wish each other on many occasions – is not a gift of the gods, of star or of magic. Scientifically, health means a highly complex and dynamic product of interaction of the variable genes, eco-social environment and individual health behaviour. Health is not a state at all, it is not something that one can “possess”. Health has to be created continually on each (bio-psycho-eco-social) system level.¹³

The more recent definition of the right in the *ICESCR* expanded considerably on the WHO definition. As well, *General Comment No. 14* explains that the concept of the highest attainable standard of health contained in Article 12.1 takes into account “the individual’s biological and socio-economic preconditions”:

...genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual’s health.¹⁴

General Comment No. 14 divides the right to health into freedoms and entitlements:

¹⁰ CESCR Committee On Economic, Social and Cultural Rights, Twenty-second session, Geneva, 25 April-12 May 2000, Agenda item 3.

¹¹ United Nations Committee on Economic, Social and Cultural Rights, *General Comment No 14: The Right to the Highest Attainable Standard of Health*, UN Doc E/C/2000/4, 11 August 2000, paragraph 9. The General Comment is available at <http://www.unhcr.ch/tbs/doc.nsf/%28symbol%29/E.C.12.2000.4.En> [accessed 3 September 2013].

¹² *Ibid* paragraph 8. Emphasis in the original.

¹³ Egger, Josef W, “Biopsychosocial Medicine and Health – the *body mind unity theory* and its dynamic definition of health” (2013) 24 1 *Psychologische Medizin* 28.

¹⁴ Above n 11.

The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.¹⁵

Aside from the ratification of international instruments, the constitutions of UN Member States can indicate their commitment to the right to health for citizens. Additionally, a constitution is commonly more difficult to repeal or amend than statute and, therefore, a relatively stable commitment. A recent analysis by Heymann et al of the constitutions of 191 Member States revealed that the term "the right of health" tends to be used in three basic categories. When a constitution did not refer to one of these categories specifically, but mentioned other health rights, these references were assigned to one of the three main categories:¹⁶

1. the broad right to overall health included:¹⁷
 - health protection
 - health security
 - a life free of illness or disease
2. the right to medical care included:¹⁸
 - cure, restoration or rehabilitation of citizens' health
 - adequate health facilities
 - access to health facilities
 - curative services
 - medical aid
 - medical assistance
3. the right to public/preventive health included:¹⁹

¹⁵ Ibid paragraph 8.

¹⁶ Heymann, Jody et al, "Constitutional rights to health, public health and medical care: The status of health protections in 191 countries", (2013) *Global Public Health: International Journal for Research, Policy and Practice*, 2, 3, DOI: 10.1080/17441692.2013.810765
<http://dx.doi.org/10.1080/17441692.2013.810765> [accessed 21 July 2013] 3-4.

¹⁷ Ibid 4. The study authors chose not to interpret constitutional references to specific areas of health, such as sexual or occupational health as the equivalent to a general right to health.

¹⁸ Ibid. The study authors chose not to include, as part of the general right to medical care, any constitutional references to specific areas of medical care such as the regulation of the production and sale of pharmaceutical items, the promotion of modern medicine, the promotion of medical technology, or guarantees of access to specific treatments such as mental health or reproductive services.

- prevention of illness or disease
- guaranteed access to preventive or prophylactic services

The study found that, in 2011, 36% of Member States' constitutions guaranteed the overall right to health while 13% aspired to this right; 38% guaranteed the right to medical care with 14% aspiring to the right generally and a further 4% aspiring only in the context of specific groups of citizens; and 25% of constitutions either guaranteed or aspired to protect the right to public health.²⁰

THE PLACE OF NON-DISCRIMINATION AND EQUAL TREATMENT WITHIN THE RIGHT TO HEALTH

Following the *ICESCR*, a number of more recent UN instruments protect the right to “the highest attainable standard” of health or otherwise express the right to health. For example:

- Article 5(e)(iv) of the *International Convention on the Elimination of All Forms of Racial Discrimination* (1969)²¹
- Articles 11(1)(f), 12 and 14(2)(b) of the *Convention on the Elimination of All Forms of Discrimination against Women* (1981)²²
- Articles 17, 23(3) & (4), 24, 25 and 32 of the *Convention on the Rights of the Child* (1990)²³
- Articles 28, 43(1)(e), 45(1)(c) and 70 of the *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families* (2003)²⁴
- Article 25 of the *Convention on the Rights of Persons with Disabilities* (2008)²⁵

¹⁹ Ibid. The study authors chose not to include constitutional references to specific areas of public health, such family planning or nutrition, if the broader right of health was not also mentioned.

²⁰ Ibid.

²¹ *International Convention on the Elimination of All Forms of Racial Discrimination*, 4 January 1969, 66 UNTS 195: the right to public health and medical care.

²² *Convention on the Elimination of All Forms of Discrimination Against Women*, 3 September 1981, 1249 UNTS 13: the right to health in working conditions; the right to access health care services, including for rural women. See also Article 10(h): access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.

²³ *Convention on the Rights of the Child*, 2 September 1990, 1577 UNTS 3: “the right...to the enjoyment of the highest attainable standard of health”; facilities responsible for the care of children conform with health standards; access to information about health; the right to periodic review of mental and physical health treatment for children in care placements; the right to be free of economic exploitation that would be harmful to health.

²⁴ *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families*, 1 July 2003, 2220 UNTS 3: the right to emergency medical care; access to health services for workers and their families; the right to healthy living conditions.

²⁵ *Convention on the Rights of Persons with Disabilities*, (3 May 2008), 2515 UNTS 3: “the right to the enjoyment of the highest attainable standard of health”.

Non-discrimination is the common theme of all these conventions. *Fact Sheet No. 3*, jointly produced by WHO and the Office of the United Nations High Commissioner for Human Rights, inextricably, links non-discrimination and equality to “fundamental human rights and critical components of the right to health”.²⁶ Therefore, violating these broader rights, such as freedom from racial or gender-related discrimination, will adversely affect the health of individuals.

The Fact Sheet’s non-exhaustive list of grounds of discrimination is drawn from the *ICESCR* and its interpretive committee, the *Convention on the Rights of the Child* and the *International Convention on the Elimination of All Forms of Racial Discrimination*.²⁷ The list includes discrimination on the basis of race, colour, national or social origin, sex, language, religion, political or other opinion, property, disability, birth or other status (which may include sexual orientation and HIV/AIDS status).

General Comment No. 14 reminds Member States that the *ICESCR* denounces any discrimination which prevents or inhibits access, not just to timely and safe health care, but to basic determinants of health such as water quality, adequate sanitation, safe food supplies, nutrition, housing, healthy work and environmental conditions, and education on health issues.²⁸

AN ASPIRATIONAL OR BINDING RIGHT?

Amongst the primary obligations agreed to by States Parties to the *ICESCR*, is the obligation to fulfil the right to health. Within this obligation to fulfil are further obligations to facilitate, provide and promote the right.²⁹

The impact of a country’s lack of resources upon the goal of attaining “the highest attainable standard” of health is a contentious issue. Is the highest possible standard a legal right or moral right? Is the standard binding or aspirational, absolute or relative?

The WHO *Global Strategy for Health for All by the Year 2000*, unanimously, adopted by the UN’s General Assembly in 1981, states that “there is a health baseline below which no

²⁶ UN Office of the High Commissioner for Human Rights/World Health Organization, *Fact Sheet No. 31, The Right to Health*, June 2008, No. 31, 7 <http://www.refworld.org/docid/48625a742.html> [accessed 27 July 2013].

²⁷ Article 2(2) of the *International Covenant on Economic, Social and Cultural Rights*, Article 2(2) of the *Convention on the Rights of the Child*; Article 2(1) of the *Convention on the Rights of the Child* and Article 5 of the *International Convention on the Elimination of All Forms of Racial Discrimination*.

²⁸ Above n 11, paragraph 18. Referring to Articles 2.2 and 3 of the *ICESCR*.

²⁹ *Ibid* paragraph 33.

individuals in any country should find themselves”.³⁰ The WHO *Fact Sheet No. 31* stipulates that the right to health “is NOT only a programmatic goal to be attained in the long term...”³¹ The *Fact Sheet* continues:

A country’s difficult financial situation does NOT absolve it from having to take action to realize the right to health. It is often argued that States that cannot afford it are not obliged to take steps to realize this right or may delay their obligations indefinitely. When considering the level of implementation of this right in a particular State, the availability of resources at that time and the development context are taken into account. Nonetheless, no State can justify a failure to respect its obligations because of a lack of resources.³²

These comments indicate that a country’s lack of resources does not absolve it from the requirement to achieve the necessary standard, and that this is essentially an absolute standard.

Nonetheless, other comments suggest that the standard is relative to the resources available. *General Comment No. 14* states that the term “the highest attainable standard” of health in Article 12.1 of the *ICESCR* incorporates both individual citizens’ “biological and socio-economic preconditions and a State’s available resources”.³³ The *Global Strategy for Health for All by the Year 2000* defines “highest attainable” as “highest possible”. In other words, “different countries will strive to improve the health of their people in keeping with their social and economic capacities”.³⁴

So countries with fewer resources are permitted to progressively realise the highest attainable standard. But the most accurate view is that the obligation is multi-tiered. The immediate provision of two important aspects of the right is non-negotiable.

General Comment No. 3, issued in 1990 by the Office of the United Nations High Commissioner for Human Rights, explains the obligations of States Parties in implementing Article 12 of the *ICESCR*. There is an immediate obligation to take “deliberate, concrete and targeted” steps towards realising Article 12. The other immediate obligation is to ensure the right to health is exercised without discrimination.³⁵

³⁰ World Health Organisation *Global Strategy for Health for All by the Year 2000* (1981) “Health for All” Series No. 3 31 <http://whqlibdoc.who.int/publications/9241800038.pdf> [accessed 19 July 2013].

³¹ Above n 26, 5. Emphasis in the original.

³² *Ibid* 7. Emphasis in the original.

³³ *Ibid*.

³⁴ Above n 30.

³⁵ UN Office of the High Commissioner for Human Rights, *CESCR General Comment 3: The nature of States parties obligations* (Art. 2, par.1): 1 12/14/1990.

Fact Sheet No. 31 also addresses the obligation of States Parties to give immediate effect to developing action plans and specific legislation and to ensuring non-discrimination. The Fact Sheet gives the examples of States' responsibility to provide maternal and child services and essential drugs.³⁶

Further, CESCR's *General Comment No. 14* qualifies the understanding that countries with fewer resources may progressively achieve the right to health. CESCR stresses that the elimination of health-related discrimination can be achieved with minimal resources through legislative avenues and the dissemination of information. The Committee refers back to *General Comment No. 3* and endorses the view therein that "even in times of severe resource constraints, the vulnerable members of society must be protected by the adoption of relatively low-cost targeted programmes."³⁷

AUSTRALIA

Australia is a party to the *ICESCR* and conventions that contain the right to the "highest attainable standard" of health.³⁸ It has not, however, imported this standard into domestic law.³⁹ As well, the country has no national Human Rights Act.⁴⁰ In 2009, a Human Rights Act was mooted but rejected, despite the recommendations of a

<http://www.unhchr.ch/tbs/doc.nsf/0/94bdbaf59b43a424c12563ed0052b664> [accessed 28 July 2013]. Referring to Articles 2.1 & 2.2 of the *International Covenant on Economic, Social and Cultural Rights*.

³⁶ Above n 26, 5.

³⁷ Above n 11, paragraph 18 & n 35, paragraph 12.

³⁸The *Convention on the Rights of the Child* and the *Convention on the Rights of Persons with Disabilities*.

³⁹ Commonwealth Acts have incorporated some specific aspects of the right to health stemming from international obligations. The *Racial Discrimination Act 1975* gives effect to Australia's obligations under the *Convention on the Elimination of all Forms of Racial Discrimination*, specifically, the right to public health and medical care; and the *Sex Discrimination Act 1984* gives effect to Australia's obligations under the *Convention on the Elimination of All Forms of Discrimination Against Women* and includes the right to health education, workplace health and equal access to health care. An example of State legislation incorporating a right to health is the *Youth Justice Regulation 2003*, which was passed by the Queensland Parliament. Section 33(1) gives children in justice detention centres (juveniles refused bail or who have been sentenced) a right to health services and medical treatment. Obviously, occupational health and safety laws impose a right to health in the workplace, though are sometimes viewed more as a right to be free of harm rather than a positive right to health. In June 2012, at the Clustered Interactive Dialogue with the Special Rapporteur on Health and the Special Rapporteur on Education, for the 20th Session of the UN Human Rights Council, the Australian Statement agreed that "occupational health and safety is an integral component of the right to health". The workplace health issue addressed by Australia was asbestos:

<http://www.geneva.mission.gov.au/gene/Statement338.html> [last viewed 20 July 2013].

⁴⁰ The State of Victoria has the *Charter of Human Rights and Responsibilities Act 2006* and the Australian Capital Territory (ACT) has the *Human Rights Act 2004*. Neither Act contains a right to health. The ACT Act was amended in 2008 to include an independent cause of action, while the Victorian Act does not contain a cause of action.

government-appointed consultation committee. The committee recommended, additionally, that if economic, social and cultural rights were to be incorporated into a new Commonwealth Act, the recognition of the right to the enjoyment of the highest attainable standard of physical and mental health should be a priority.⁴¹

As with the constitutions of China and the United States of America, Australia's Constitution does not refer to a right to health. Through an extensive review of the right to health in 194 countries, Backman et al note that most countries have not incorporated the right to health into national constitutions.⁴² Section 51(xxiiiA) of the Australian Constitution refers only minimally to health in granting the Commonwealth the power to legislate for medical and dental services.⁴³ Importantly though, the High Court of Australia decided in the *Tasmanian Dam* case that the external affairs power under Section 51(xxix) of the Constitution can be used as a source of legislative authority to incorporate international treaties into domestic Australian law.⁴⁴

A number of Federal and State departments are charged with the administration of health in Australia. The primary agency is the Department of Health and Ageing. Federally, the responsibilities are spread across four ministers.⁴⁵ In 2008, these ministers and the health ministers from each state endorsed the *Australian Charter of Healthcare Rights*, which was developed by the Australian Commission on Safety and Quality in Health Care. The Charter outlines the rights of patients seeking or receiving health care. It is currently the only document that expresses Australia's commitment to the *ICESCR's* declared right of "everyone" to the highest possible standard of physical and mental health.⁴⁶ The basic premise of the Charter is that Australians have a right to safe,

⁴¹ National Human Rights Consultation Committee, *National Human Rights Consultation Report*, September 2009, 366.

⁴² Backman, G et al., "Health systems and the right to health: An assessment of 194 countries", (13 December 2008) *The Lancet*; 372 9655 2047-85 DOI:10.1016/S0140-6736(08)61781-X [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(08\)61781-X/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(08)61781-X/abstract) [accessed 3 June 2013].

⁴³ Section 51 (xxiiiA) - the provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription), benefits to students and family allowances.

⁴⁴ *Commonwealth v Tasmania* ("Tasmanian Dam case") [1983] HCA 21; (1983) 158 CLR 1 (1 July 1983).

⁴⁵ Within the Department for Health and Ageing is the Office for Aboriginal and Torres Strait Islander Health (OATSIH). There are ministers for Health and Ageing; for Indigenous Health, Rural and Regional Health and Regional Services Delivery; for Ageing, Minister for Early Childhood Education, Child Care and Youth/Minister for Sport.

⁴⁶ Australian Commission on Safety and Quality, *Australian Charter of Healthcare Rights in Victoria*, 4 [http://docs.health.vic.gov.au/docs/doc/A828F4D7161E1D77CA2578AA007DDA38/\\$FILE/1105029_ACHCR_A5_FA_web.pdf](http://docs.health.vic.gov.au/docs/doc/A828F4D7161E1D77CA2578AA007DDA38/$FILE/1105029_ACHCR_A5_FA_web.pdf) [accessed 1 July 2013].

high quality, respectful health care.⁴⁷ It is intended to give guidance to patients and service providers and is not binding upon providers or the government.

At the invitation of the Australian government, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health visited Australia in 2009. The Special Rapporteur reports to the United Nations Human Rights Council. His subsequent report on his Australian mission, though a model of diplomacy, expressed his concern about the health services provided to detainees in prisons and migration centres and to the indigenous population.⁴⁸ Eighteen of his twenty recommendations addressed these specific concerns. The remaining two called upon the government to enshrine the right to the highest attainable standard of health, and to develop a detailed plan and national health policy to fully realise the right to health.⁴⁹

Given the legal hurdles, it is unsurprising that Australia has yet to produce case law dealing with the right to the highest attainable standard of health.

RIGHT TO HEALTH CASES

The Expansive Approach

Three countries have developed an expansive approach with individual justiciability of the constitutional right to health: India, Columbia and Brazil. As India is a common law country, its courts interpret its laws and, in certain cases, create laws, through precedent. Indian courts have read the right to health into their Constitution by judicial

⁴⁷ Australian Commission on Safety and Quality, *Australian Charter of Healthcare Rights* (2007-2008), <http://www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights/> [accessed 30 June 2013].

⁴⁸ Indigenous Australians experience poorer health and have a substantially lower life expectancy than non-Indigenous Australians. Asylum seekers released from detention centres into the community on bridging visas are ineligible for entitlements under the Pharmaceutical Benefits Scheme, which allows access to subsidised access medications, and Medicare, so are prevented from accessing Australia's public health system. Howie, Emily, Victoria Edwards and Philip Lynch, Human Rights Law Resource Centre [now Human Rights Law Centre], *Briefing Paper on Key Issues on the Right to Health in Australia* (September 2009) <http://www.hrlrc.org.au/files/Briefing-Paper-Health-in-Australia-September-2009.pdf> [accessed 20 May 2013].

⁴⁹ Human Rights Council, Fourteenth session, Agenda item 3, *Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, Addendum: Mission to Australia* (3 June 2010) 22-24 http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session20/A.HRC.20.18.Add.1_En.PDF [accessed 15 May 2013].

interpretation, whilst the other two countries have incorporated it directly into their Constitutions by verbatim provisions.

India

The right to health is not directly mentioned in the Constitution of India, which was adopted in 1949.

In Part III of the Constitution, however, entitled “Fundamental Rights”, Article 21 reads: “No person shall be deprived of his life or personal liberty except according to procedure established by law”. Originally, this provision bound only the actions of the executive, but the decision in the case of *Maneka Gandhi vs Union of India* extended its reach to require legislative action to be just, fair and reasonable.⁵⁰ Article 21 has become a gateway to action enforcing a practical right to access health care, offering an alternative route to the main source of enforcement under the *Consumer Protection Act 1986*.

The first harbinger of reading a right to health into the Constitution was *Francis Coralie Mullin vs The Administrator, Union Territory of Delhi & ors*,⁵¹ where the Supreme Court of India spoke of the “fundamental right to life which is the most precious human right” and held that all other rights must be broadly interpreted to apply this right.⁵² This statement opened up the possibility of formulating a right to health as an extension of the right to life under Article 21.

In *Bandhua Mukti Morcha vs Union of India & Others*,⁵³ the Supreme Court faced a claim that stone quarry workers were employed under inhumane conditions in breach of their constitutional right. The Court decided that the state had an active duty to abolish these conditions based upon Article 21, again widening its practical scope following *Francis Coralie Mullin*.

The first Supreme Court case to apply this extended principle to health care law was *Vincent Panikurlangara vs Union of India & Ors*, where the petitioner attempted to suppress manufacturing and sale of potentially harmful drugs prohibited in other countries.⁵⁴ The Court stipulated, citing Article 25(2) of the *Universal Declaration of Human Rights* as well as, inter alia, Article 21: “A healthy body is the very foundation for all human activities ... In

⁵⁰ 1978 AIR 597, 1978 SCR (2) 621, 658f.

⁵¹ 1981 AIR 746, 1981 SCR (2) 516.

⁵² 527 C-D, 528 A-C.

⁵³ 1984 AIR 802, 1984 SCR (2) 67.

⁵⁴ 1987 AIR 990, 1987 SCR (2) 468.

a welfare State, therefore, it is the obligation of the State to ensure the creation and the sustaining of conditions congenial to good health.”⁵⁵ The requirement that the State “ensure” conditions “congenial to good health” is equivalent to a right to health.

Eventually, the Court was faced with a direct refusal to provide medical care to a citizen. In *Pt. Parmanand Katara vs Union of India & Ors*, the petitioner filed a writ in the public interest regarding a scooterist who was fatally hit by a car.⁵⁶ The injured person was transported to the nearest hospital, where he was refused medical help and sent to another hospital. He died en route to the second hospital. The petitioner claimed that lifesaving medical treatment should have been given without delay. The Court held that Article 21 casts the obligation to preserve life on the State:⁵⁷

Every doctor whether at a Government hospital or otherwise has the professional obligation to extend his services with due expertise for protecting life. No law or State action can intervene to avoid/delay the discharge of the paramount obligation cast upon members of the medical profession. The obligation being total, absolute and paramount, laws of procedure whether in statutes or otherwise which would interfere with the discharge of this obligation cannot be sustained and must, therefore, give way.⁵⁸

The strength of the State’s obligation could not have been expressed more forcefully, but its scope remained uncertain until the Court’s pronouncement in *Paschim Banga Khet Majoor Samity vs State of West Bengal*.⁵⁹ In this case, an agricultural labourer was seriously injured in a train accident. He was transported to no fewer than six hospitals and refused admission either due to a lack of facilities or, in most cases, a lack of beds. Eventually, he received treatment in a private hospital at a high financial cost. The victim was the joint petitioner together with an organisation of agricultural labourers, of which he was member.

The Court again held that failure on the part of a State hospital to deliver timely emergency medical treatment is a violation of the right to life under Article 21. The patient had arrived at the various hospitals in a dangerous condition necessitating immediate medical care. The Court insisted that acute medical care must not be denied.

Other cases have buttressed an expansive reading of Article 21, such as *Smt. Gian Kaur vs*

⁵⁵ 1987 SCR (2) 46, 477.

⁵⁶ 1989 AIR 2039, 1989 SCR (3) 997.

⁵⁷ 1989 SCR (3) 997, 1005G.

⁵⁸ 1989 SCR (3) 997, 1006.

⁵⁹ (1996) 4 SCC 37.

The State of Punjab,⁶⁰ where the Court defined “life” as “life with dignity”. The Court expressed the view that a life with dignity is difficult to imagine when basic health care is refused. Additionally, the Court was prepared to order practical adjunct interventions enabling the provision of health care. In the 1996 case *State Of Punjab & Ors vs Mohinder Singh Chawla Etc*, the Court approved an Article 21 claim for compensation of rent when the patient was forced to stay in another area for specialist treatment not available locally.⁶¹

India has become a paradigmatic example of the highest court in a country using a broader constitutional right to life to construct a doctrine encompassing the narrower right to health by implication, and to enforce the latter as an individual right against the State. Being derived from the right to life, it was to be expected that the scope of the right of health would be restricted to life-saving emergency care, but the *State of Punjab* case has broadly extended this right.⁶²

Columbia

In contrast to India, Columbia has a direct constitutional right to health. This right is guaranteed in the Columbian Constitution of 1991 through Article 49:⁶³

Public health and environmental protection are public services for which the state is responsible. All individuals are guaranteed access to services that promote, protect, and rehabilitate public health.

It is the responsibility of the state to organize, direct, and regulate the delivery of health services and of environmental protection to the population in accordance with the principles of efficiency, universality, and cooperation, and to establish policies for the provision of health services by private entities and to exercise supervision and control over them. In the area of public health, the state will establish the jurisdiction of the nation, territorial entities, and individuals, and determine the shares of their responsibilities within the limits and under the conditions determined by law. Public health services will be organized in a decentralized manner, in accordance with levels of responsibility and with the participation of the community.

⁶⁰1996 AIR 946, 1996 SCC (2) 648.

⁶¹ Civil Appeal Nos.16980-81 OF 1996.

⁶² See also Srivastava, Lily “Law and Medicine”, (2013) Universal Law Publishers.

⁶³ Article 49 as amended by *Acto Legislativo 2* de 2009 L. 2/09, 21 December 2009. See also Young, Katharine G. & Julieta Lemaitre, “The Comparative Fortunes of the Right to Health: Two Tales of Justiciability in Colombia and South Africa” (2013), *Harvard Human Rights Journal Vol. 26*, No. 1 179-216.

The law will determine the limits within which basic care for all the people will be free of charge and mandatory.

Every person has the obligation to attend to the integral care of his/her health and that of his/her community.⁶⁴

The statement “All individuals are guaranteed access to services that promote, protect, and rehabilitate public health” can be said to express a right to health, following the approach of Heymann et al, discussed above.⁶⁵

This constitutional provision has been awarded the character of an institutional guarantee, ie a provision that cannot be overruled or abolished by the legislature. The Columbian Constitutional Court (*Corte Constitucional*) has viewed this provision as a straightforward rule and, unhesitatingly, applied it wherever appropriate. Some of the more salient examples include:

- Case *T-597/93* on 25 December 1993 – The Court ordered post-operative orthopedic treatment for a disabled child that was not included in the treatment originally.⁶⁶
- Case *T-271/95* on 23 June 1995 – The Court ordered the dispensing of HIV medication, which was not on the schedule list at that time, to patients where medically indicated.
- Case *T-571-95* on 1 December 1995 – The Court prescribed an operation for a child, although the procedure was not on the schedule list of approved procedures.

Whilst the Constitutional Court was careful not to usurp the role of medical professionals in determining treatment, it applied Article 49 without hesitation as soon as access to the proposed medical intervention was the apparent issue. Most importantly for our discussion below, a lack of resources was not regarded as a valid excuse for the state to refuse to such an intervention. The constitutional right was clearly seen by the Court as a specifically enforceable individual right.

In the 2006 decision *T-760/08*, the Court looked at various State and non-government benefits and ordered their unification to ensure more effective care and compliance with

⁶⁴ http://confinder.richmond.edu/admin/docs/colombia_const2.pdf [accessed 27 July 2013].

⁶⁵ Heymann, above n 16.

⁶⁶ <http://www.corteconstitucional.gov.co/relatoria/1993/t-597-93.htm> [accessed 27 July 2013].

the constitutional right to health. The Court explicitly adopted the right to health contained in CESCR's *General Comment No. 14*. This case affirmed the State's obligation to actively provide health care. The Court held that the right to health contains a core nucleus (*nucleo esencial*), also known as the core services doctrine, which must be guaranteed to all. Although this core was not defined in detail, cases claiming cosmetic surgery under the constitutional right to health have been unsuccessful in Columbia.⁶⁷

In the publication *Defensoría del Pueblo de Colombia*,⁶⁸ produced by the Observatorio de Justicia Constitucional – an Ombudsman-style organisation distributing summaries of legal issues and court cases to the public – the term “derechos fundamentales ... a la salud”, meaning “fundamental rights to ... health”, is used verbatim. Equally unequivocally, in Case *T-760/08* of 31 July 2008, the Constitutional Court summarises the cases applying the right to health and emphasises the obligation of the state to ensure free health services are enjoyed by those in need.⁶⁹ The Observatorio de Justicia Constitucional reported that, between 1999 and 2008, 674,612 actions were brought to enforce the constitutional right to health.⁷⁰

Having established the right to health as a constitutional guarantee in Columbia, the State has increased health care funding considerably since the Constitution was promulgated in 1991. From 1993 to 2008, Columbia's health sector budget rose to 7.8% of its gross domestic product. This is above average for the region.⁷¹

From 2007 onwards, the Court became increasingly critical of the doctrine of fundamental rights⁷² based on an individual being part of a class insured by a private entity or the State. Case *T-760/08* marked the watershed as the Court, once and for all, overruled this doctrine⁷³ and held that the right to health applies to all individuals directly.

In paragraph 3.5.2. of Case *T-760/08*, the Court lists some examples of cases in which treatments and services have been denied, including:

⁶⁷ Yamin, Alicia Ely & Oscar Parra-Vera, “Judicial Protection of the Right to Health in Colombia: From Social Demands to Individual Claims to Public Debates”, *Hastings International and Comparative Law Review* 33 2 101-129 117ff.

⁶⁸Section 1.1. <http://www.defensoria.org.co.ojc/pdf.php/4> [accessed 27th July 2013].

⁶⁹ Paragraph 4.1.5.ff.

⁷⁰ Yamin, above n 67, 102.

⁷¹ Ibid 104.

⁷² Ibid 112.

⁷³ Colombian Constitutional Court, *Judgment T-760/2008*

http://www.esccr-net.org/usr_doc/English_summary_T-760.pdf [accessed 27th July 2013]. This right is directly enforceable by the action of the *tutela* (guardian) in the Constitutional Court.

- (i) cosmetic treatments and surgeries...
- (ii) eyeglasses and refractive eye surgery...
- (iii) fertility treatments...
- (iv) alcoholic rehabilitation/detoxification...
- (v) prostheses not included in the POS [an insurance scheme]...
- (vi) gastric bypass surgery...
- (vii) dental services...
- (viii) certain allergy treatments using vaccines...

Despite these limitations, in 2008, the Administration of President Uribe stated that the Court's approach was too expensive for the state.⁷⁴

Brazil

Columbia is not the only Latin American country where courts have examined the issue of accessibility to health care. In *Aquino, Isacio vs. Cargo Servicios Industriales S. A.*, the Supreme Court of Argentina struck down a 1995 law which severely circumscribed compensation for employment injury on the basis that it would violate a wide range of international standards, including the ICESCR.⁷⁵ Nonetheless, next to Columbia, the country with the most developed jurisprudence and litigation to enforce a right to health is Brazil. Similarly to Columbia, the promulgation of a new constitution emboldened the judiciary to take a more active role in this area.⁷⁶

Brazil's new constitution was adopted in 1988. Article 6 of this constitution states that "[e]ducation, health, work, housing, leisure, security, social security, protection of motherhood and childhood, and assistance to the destitute, are social rights under this Constitution".⁷⁷

⁷⁴ Yamin, above n 67, 121.

⁷⁵ *Aquino, Isacio vs. Cargo Servicios Industriales S. A. s/accidentes ley 9688, 2004*. A more detailed discussion of the situation in other Latin American countries can be found in: Yamin, Alicia Ely & Siri Gloppen, "Litigating Health Rights: Can Courts Bring More Justice to Health?", 2011, Harvard University Press, Cambridge, Massachusetts.

⁷⁶ Ferraz, Octavio Luiz Motta, "Right to health litigation in Brazil: Why are collective suits so hard to enforce?", University of Warwick, School of Law. http://www.escri-net.org/sites/default/files/Ferraz_-_Implementing_the_Right_to_Health_in_Brazil_0.pdf [accessed 24 July 2013]. For general advice regarding material on Brazilian Law we acknowledge the generous assistance of Judge José Luiz Valentino, Master of Constitutional Law, of the Tribunal Regional do Trabalho 1º Região in Rio de Janeiro.

⁷⁷ *Ibid.* For a general introduction to the Brazilian Constitution see Brandão de Oliveira, Cláudio, *Constituição da República do Brasil*, 2003, Roma Victor Editoria Rio de Janeiro RJ.

Additionally, Article 196 states:

Health is a right of all and a duty of the State and shall be by means of social and economic policies aimed at reducing the risk of illness and other hazards and at the universal and equal access to actions and services for its promotion, protection and recovery.⁷⁸

Since then, an explosion of thousands of cases in the courts claiming access to specific health interventions has led to the coining of the phrase “the judicialisation of health”. The interventions include access to surgery and drugs. Most of these cases have been individual claims, rather than enforcements of access to collective health programmes.

Official data show that 17,025 health-related lawsuits were brought against the State of Rio Grande do Sul in 2009; of which 12,179 requested access to drugs. In 2008, 12,262 health-related lawsuits were brought, with 8,559 requesting medicines. The same year, Rio Grande do Sul had a population of approximately 11 million people and spent US\$30.2 million on judicially-accessed drugs; which amounts to 22% of the State’s total expenditure on drugs in that period.⁷⁹

In recent years, cases brought to challenge refusals of access to medical care and other social rights have skyrocketed.⁸⁰ The Brazilian Supreme Federal Tribunal (Supremo Tribunal Federal, “STF”) presides over thousands of such cases each year, whereas the Constitutional Court of South Africa hears approximately 10 to 30 cases.⁸¹ Messeder et al traced the evolution of the right to health litigation in the State of Rio de Janeiro from a single lawsuit in 1991 to 1,144 suits in 2002.⁸²

⁷⁸ <http://www.v-brazil.com/government/laws/constitution.html> [accessed 27 July 2013]; see also Zimmerman, Augusto, *Curso de Direito Constitucional*, 2002, Editoria Lumen Juris Rio de Janeiro 564.

⁷⁹ Biehl, João, “Right to Health Litigation”, <http://joaobiehl.net/global-health-research/right-to-health-litigation/> [accessed 27th June 2013].

⁸⁰ Langford, Michael, “Domestic adjudication and Economical, Social and Cultural Rights: a socio-legal review”, http://www.surjournal.org/eng/conteudos/getArtigo11.php?artigo=11,artigo_05.htm [accessed 27 July 2013]. See also the overview in Langford, Michael, “Justiciability of Social Rights: From Practice to Theory.” In *Social Rights and Jurisprudence: Emerging Trends in International and Comparative Law* (2008) New York: Cambridge University Press 1-45.

⁸¹ Ferraz, Octavio Luiz Motta, “Between Usurpation and Abdication? The Right to Health in the Courts of Brazil and South Africa” (20 August 2009) University of Warwick School of Law, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1458299 [accessed 27 July 2013] 6, see also 10ff.

⁸² Messeder, Osorio-de-Castro e Luiza, “Mandados judiciais como ferramenta para garantia do acesso a medicamentos no setor público: a experiência do Estado do Rio de Janeiro, Brasil” (“Can court injunctions guarantee access to medicines in the public sector? The experience in the State of Rio de Janeiro, Brazil”), *Cad. Saúde Pública*, 21(2): 525-534, (March-April 2005) 527.

A reason that such cases are brought easily could be the important group of test cases in the State of Rio Grande do Sul⁸³ and its capital Porto Alegre.⁸⁴ The courts decided, in what has now become established jurisprudence, that the duty to provide care under the Constitution is owed jointly by all levels of the Brazilian state administration and the claimant can choose against which administrative level to bring the action.

Most impressively, on a doctrinal level, the STF held in case *RE 271.286 AgR* that:

... Between protecting the inviolable rights to life and health, which are subjective inalienable rights guaranteed to everyone by the Constitution itself (Art. 5 caput [heading] and Art. 196), and the upholding, against this fundamental prerogative, of a financial and secondary interest of the State, I believe that – once this dilemma occurs – ethical juridical reasons compel the judge to only one possible solution: that which furthers the respect of life and human health ...⁸⁵

The right to health – as well as a fundamental right of all individuals – represents an inextricable constitutional consequence of the right to life. (...) The interpretation of a programmatic norm cannot transform it into a toothless constitutional promise (...)⁸⁶

Resources were not the issue in this case. Nevertheless, since these actions are mainly brought privately at considerable cost, there were concerns that the poorer segments of the population may be unable to effectively avail themselves of this judicial remedy.⁸⁷ For instance, in the City of São Paulo, 47% of Court-ordered prescriptions were issued by

⁸³ *RE 242.859/RS*.

⁸⁴ *RE/AgR 271.286-RS*.

⁸⁵ The original Portuguese: “entre proteger a inviolabilidade do direito à vida e à saúde, que se qualifica como direito subjetivo inalienável assegurado a todos pela própria Constituição da República (art. 5º, caput e art. 196), ou fazer prevalecer, contra essa prerrogativa fundamental, um interesse financeiro e secundário do Estado, entendo - uma vez configurado esse dilema - que razões de ordem ético-jurídica impõem ao julgador uma só e possível opção: aquela que privilegia o respeito indeclinável à vida e à saúde humana...” www.stf.gov.br [accessed 28 July 2013].

⁸⁶ *RE 271.286 AgR- RS*, Relator Ministro Celso de Mello, <http://www.stf.gov.br/> [accessed 28 July 2013]. This is the original Portuguese: “O direito à saúde - além de qualificar-se como direito fundamental que assiste a todas as pessoas - representa consequência constitucional indissociável do direito à vida...A interpretação da norma programática não pode transformá-la em promessa inconsequente...Entre proteger a inviolabilidade do direito à vida, que se qualifica como direito subjetivo inalienável assegurado pela própria Constituição da República (art. 5º, caput), ou fazer prevalecer, contra essa prerrogativa fundamental, um interesse financeiro e secundário do Estado, entendo - uma vez configurado esse dilema. In Ferraz, above n 81, 25.

⁸⁷ Ferraz, Octavio Luiz Motta, “Harming the Poor Through Social Rights Litigation: Lessons from Brazil”, *Texas Law Review* 89:1643-1668, 1662 <http://www.corteidh.or.cr/tablas/r27170.pdf> [accessed 24 July 2013]. The state-based Defensor Público can facilitate free access for low-income claimants.

private medical practitioners and three-quarters of the patients lived in high-income neighbourhoods.⁸⁸

In Brazil, as with most civil law countries, individual cases do not establish legal precedent.⁸⁹ The courts, however, have not limited access to the judicial system for those seeking to challenge administrative decisions to refuse health care. Arguably, Brazil's explicit endorsement of a guaranteed constitutional right to health has created the most prolific litigation to enforce this fundamental right.

The Restrictive Approach

Two jurisdictions regard the right to health as a collective public right at best, rather than individually enforceable, and limit this right by refusing to interfere with resource allocation decisions of the states' health administration: England & Wales and South Africa.

England & Wales

There is no constitutional right to health in any form in this jurisdiction. Further, the *UK Human Rights Act 1998* does not contain a right to health and includes only a limited right to life.⁹⁰ Therefore, a challenge to the refusal to access care by a medical administration in the National Health Service (NHS) must rely on the common law of judicial review.

The starting point in resource allocation decision-making is the doctrine of reasonableness as evinced originally in *Associated Provincial Picture Houses Ltd. v Wednesbury Corporation*.⁹¹ This case involved the decision-making process for granting a cinema licence to open on Sundays. It became one of the early landmark cases of judicial review in England. In his leading judgment, Lord Greene MR held that licensing decisions must be exercised reasonably.⁹²

Lord Greene MR's judgment explained that a decision would be unreasonable if it were

⁸⁸ Victoria, Cesar CG et al, Health conditions and health-policy innovations in Brazil: the way forward (11 June 2011) *The Lancet*; DOI: 10.1016/S0140-6736(11)60055-X. 377: 2042–53. 2048.

⁸⁹ Biehl, João et al, "Judicialisation of the right to health in Brazil", (27 June 2009) 373 *The Lancet* 2182–2184.

⁹⁰ Article 2.

⁹¹ (1947) 2 All L.R. 680.

⁹² This case was not uncontroversial in later years, see Syrett, Keith: "Of resources, rationality and rights: emerging trends in the judicial review of allocative decisions" [2000] 1 <http://webjcli.ncl.ac.uk/2000/issue1/syrett1.html> [accessed 24 July 2013] or webjcli.ncl.ac.uk/2000/issue1/rtf/syrett1.rtf [accessed 27 July 2013].

so absurd that no sensible person could imagine it was within the powers of the decision-making authority. The Court could also intervene if the decision of a local authority took into account irrelevant considerations or if relevant issues had been omitted from its considerations. There is potential for overlap between the considerations grounds and the unreasonableness ground.

This restrictive and high threshold for the initiation of judicial review may be one cause of what has been described as frustrating judicial passivity in this jurisdiction.⁹³

The series of cases commonly known as the Herceptin litigation established the principle that an NHS Authority must specify the circumstances under which a treatment will be made available.⁹⁴ The litigation concerned access to an expensive treatment for breast cancer. In one case, the Swindon NHS Primary Care Trust refused to dispense Herceptin to the claimant and she applied for judicial review of this decision. The Trust's failing in this litigation⁹⁵ was its policy of funding prescriptions of Herceptin only in "exceptional circumstances", which it was unable to define.

The Court stated that any decision to spend money on other clinical needs, instead of Herceptin, could have been rational and defensible if there was a shortage of funds. But the Trust had the funds available.⁹⁶ Since the drug's cost was not part of the equation, the Trust's decision to distribute Herceptin to selected patients made it acceptable that only the patients' clinical needs would be considered. There must, however, be a reasonable process in place to assess those clinical needs and any exceptional circumstances. As there was no process in place, the refusal to dispense the drug to the claimant was unreasonable.⁹⁷

Some judges have attempted to make funding decisions more justiciable. *Bull v Devon Area Health Authority*⁹⁸ was a case alleging inadequate provision of staff for the postnatal care of a baby brain-damaged by delayed delivery. Mustill LJ commented in obiter that the courts might not be able to avoid the issue forever. His Lordship noted that public services cannot necessarily escape liability by complaining that their unsafe systems are a consequence of inadequate funding. So far, however, the courts have managed to avoid a

⁹³ Foster, Charles, "Simple rationality? The law of healthcare resource allocation in England" (2007) *Journal of Medical Ethics* 33:404–407, 405.

⁹⁴ *R v North West Lancashire HA, ex parte A, D & G* [1999] 1 Lloyd's Rep Med 399 (CA), cited in *R (on the application of Ann Marie Rogers) v Swindon NHS Primary Care Trust* 89 BMLR 211, [2006] EWCA Civ 392, paragraph 62. See also Syrett, above n 92.

⁹⁵ *R (on the application of Ann Marie Rogers) v Swindon NHS Primary Care Trust* [2006] EWCA Civ 392, 89 BMLR 211.

⁹⁶ *Ibid* 62.

⁹⁷ *Ibid* 212.

⁹⁸ [1993] 4 Med LR 117.

firm decision of this issue in a medical context.

Even the passing of the *Human Rights Act* 1998, which incorporated the *European Convention on Human Rights* (ECHR) into domestic law did not change that situation significantly,⁹⁹ although Article 2 of the Act states that “Everyone’s right to life shall be protected by law...”. The European Court of Human Rights has interpreted Article 2 so that it “enjoins the State not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction”.¹⁰⁰ The Court limited this positive obligation by deciding it “must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities”.¹⁰¹ The Court, therefore, endorsed restrictions on human rights based on a lack of resources.

In possibly the most-cited case in this context, *R v Cambridge Health Authority ex parte B*,¹⁰² the Court of Appeal heard an appeal from an order of *certiorari* quashing a decision of the Cambridge Health Authority not to fund further treatment of the child by chemotherapy and a second bone marrow transplant. Sir Thomas Bingham MR said:

I have no doubt that in a perfect world any treatment which a patient, or a patient's family, sought would be provided if doctors were willing to give it, no matter how much it cost, particularly when a life was potentially at stake ... It is common knowledge that health authorities of all kinds are constantly pressed to make ends meet ... Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgment which the court can make. In my judgment, it is not something that a health authority such as this Authority can be fairly criticised for not advancing before the court.

The ratio of this case is that the Court cannot second-guess the decision of the NHS, as the government has delegated the task of rationing resources to that institution. This judgment implies that there is no individual right of the patient leading to a cause of action that may overturn such a decision by the NHS.

In *R v North and East Devon Health Authority, ex p Coughlan*,¹⁰³ the local Health Authority had confirmed to the severely disabled plaintiff her statutory right to a life-long placement in a nursing home. Later, the Authority wanted to sell the nursing home due

⁹⁹ Foster, above n 93, 405.

¹⁰⁰ *Osman v United Kingdom* (1998) 29 EHRR 245, paragraph 116.

¹⁰¹ *Ibid.*

¹⁰² [1995] 1 WLR 898.

¹⁰³ [2001] QB 213.

to strained resources and move her to another facility. The Court of Appeal upheld an order quashing the decision to close the home on the grounds that it was tantamount to “an abuse of power”, by ignoring the plaintiff’s legitimate expectation of the benefit of life-long accommodation. Additionally, as this case was brought prior to the introduction of the UK’s *Human Rights Act 1998*, the Court of Appeal relied upon Article 8 of the European Convention on Human Rights in holding that the Authority had interfered with the plaintiff’s right to respect for family and private life.¹⁰⁴

The year after the *Coughlan* case, British barrister Alec Samuels declared that, where a clear statutory duty exists, and in certain other situations, a lack of resources was no longer a defence available under English law.¹⁰⁵

The restrictive judicial approach to the right to health in England and Wales has not, in essence, changed so far. The *Coughlan* case, however, suggests that judicial attitude may possibly become more critical towards the concept of *Wednesbury*-unreasonableness and develop a more interventionist approach.

In considering international treaties, English courts have applied these instruments more adventurously in areas outside health law. When the facts of a case are unrelated to health law, and faced with a strong claim under international treaties, the House of Lords has been willing to override the most important principle of the British Constitution: absolute parliamentary supremacy. The view of the House of Lords has been that a treaty signed must be upheld, while the UK government has taken the position that signing a treaty does not equate with signing away the supremacy of the Parliament under the Constitution. The House of Lords has allowed judgments of the European Court of Justice (ECJ), which was established under the Treaties of *Paris* (1951) and *Rome* (1957), to override domestic statutes.

The most notable example is the *Factortame* series of cases.¹⁰⁶ Under the EU Common Fisheries Policy, free movement of fishery vessels and fishing rights were permitted in the waters of all Member States. In order to limit the fishing of non-UK vessels in its

¹⁰⁴ The Court held that this Article 8 right could not be interfered with due to the plaintiff’s circumstances.

¹⁰⁵ Samuels, Alec, “Right to medical treatment and the defence of lack of resources”, *Medical Litigation* (2002) 512-513.

¹⁰⁶ For example: *R v Secretary of State for Transport, ex p. Factortame Ltd and others (No. 1)* [1989] UKHL, *R v Secretary of State for Transport, ex p. Factortame Ltd and others (No.2)* [1990] EUECJ, *R v Secretary of State for Transport Ex p Factortame and others (No.2)* [1991] UKHL, *Brasserie du Pecheur SA v Bundesrepublik Deutschland and The Queen v Secretary of State for Transport, ex parte: Factortame Ltd and others* (Community law) [1996] EUECJ, *R v Secretary of State for Transport Ex p Factortame Ltd and others (No.4)* [1996] ECJ, *R v Transport Secretary, ex p Factortame and others (No 5)* [1997] EUECJ, *R v Secretary of State for Transport Ex p Factortame and others (No.5)* (1998) EWCA, *R v Secretary of State for Transport Ex p. Factortame and others (No.5)* (1999) UKHL. (2013) J. JURIS 297

waters, the British government enacted a series of legislative measures stipulating UK ownership and control of fishing vessels in its territory. The government's measures were challenged through the claim that pronouncements of the EU override UK law under the Treaties of *Rome* and *Paris*. In the initial proceedings this claim was refuted by the court. This decision was reversed by the Court of Appeal, against whose judgment the claimants appealed to the House of Lords. The claimant launched a parallel action in the ECJ, which stated that a national court must grant injunctions to allow the ECJ time to pronounce their own judgments. The House of Lords duly complied.

In its second *Factortame* decision, the House of Lords acknowledged that European law, introduced with the *Treaty of Rome* and later relevant treaties, must not only be taken into consideration, but could override national law and sovereignty.¹⁰⁷

South Africa

The right to health, as it pertains to health care, is explicitly stated in Section 27 of the South African constitution:

27. (1) Everyone has the right to have access to—
(a) health care services, including reproductive health care.¹⁰⁸

Cases claiming this constitutional right must be brought in the Constitutional Court of South Africa (CCSA), which hears up to 30 such cases each year.¹⁰⁹

The leading CCSA case dealing with access to health care is *Soobramoney v Ministry of Health (KwaZulu-Natal)*.¹¹⁰ The claimant was a patient in end-stage renal failure seeking access to dialysis, which was denied by the local state health facility in accordance with their rationing guidelines. Due to a limited number of available dialysis machines, only patients with acute renal failure were given automatic access, since they would receive the greatest benefit from this intervention. A utilitarian approach to the analysis of the constitutional right to health was preferred by the CCSA; that the available machines be allocated to those who would benefit most. Under the hospital's guidelines, the claimant was refused the desired treatment. He relied on the Indian *Paschim Banga* case, referred to above, to claim the constitutional right of access to treatment. The Court countered by adopting the restrictive English reasonableness approach and citing Sir Thomas Bingham

¹⁰⁷ *R v Secretary of State for Transport, ex p. Factortame Ltd and others (No. 2)* [1990] UKHL 13 (11 October 1990).

¹⁰⁸ *Constitution of South Africa 1996*.

¹⁰⁹ Ferraz, above n 81, 6.

¹¹⁰ *CCT 32/97, 1998 (1) SA 765 (CC)*.

MR in *R v Cambridge Health Authority*. The CCSA stated that the decision to refuse dialysis was the result of limited resources and it was not for the court to override the hospital's utilitarian approach.

Interestingly, although South Africa has a constitutional right to health, at the time *Soobramoney* was decided in 1997, the country had signed the *ICESCR*¹¹¹ but not ratified it. As South Africa's Cabinet only approved the *ICESCR* for ratification last year,¹¹² the claimant in *Soobramoney* could not rely on this Convention or, obviously, any domestic legislation that ratification would have created.

Following *Soobramoney*, the CCSA has, sometimes, ventured into a more interventionist mode. In *Government of the Republic of South Africa v. Grootboom*,¹¹³ the CCSA addressed the standard of reasonableness. Although *Grootboom* was not a case brought in the health law area, it dealt with the issue of resources, similarly to *Soobramoney*.

In *Grootboom*, a group of homeless people applied for temporary state housing. Although the housing Authority had developed a detailed housing policy, there were gaps regarding short-term emergency accommodation. The Court applied a less restrictive standard of reasonableness than in *Soobramoney*. In determining the standard of reasonableness to be applied, the Court increased the relevance of the Constitutional provisions supporting a right to housing, which could not be avoided by the Authority relying on a lack of resources.¹¹⁴

Another issue that brought the constitutional right to health into focus was the scarcity of antiretroviral drugs during the AIDS pandemic. Despite being made available by the manufacturers at no cost, the drugs remained unavailable in public hospitals. This situation occurred due to President Mbeki's ideologically based denial of a causal link between infection with HIV and illness.

On behalf of HIV patients, the Treatment Action Campaign (TAC) brought the *TAC* case before the CCSA.¹¹⁵ Although the antiretroviral drugs were donated, the Government defended its refusal to make treatment available on the basis that administering the drugs and providing the necessary counselling to the recipients would incur considerable costs.

¹¹¹ on 3 October 1994.

¹¹² on 12 October 2012.

¹¹³ *CCT11/00 [2000] ZACC 19; 2001 (1) SA 46; 2000 (11) BCLR 1169* (4 October 2000) paragraphs 52–54, 53–56.

¹¹⁴ *Ibid* paragraphs 74, 75, 83. In paragraph 75, the Constitutional Court highlighted the necessity to interpret the state's obligations "in the light of the international obligations binding upon South Africa".

¹¹⁵ *Minister of Health and Others v Treatment Action Campaign and Ors* (1) 2002 (10) BCLR 1033 (CC).

The CCSA disagreed with the Government, applying the principle of reasonableness, and ordered the Government to provide a set of services, including counselling, and to end restrictions on drug availability to patients. The *TAC* case was the high-water mark in litigation over the right to health in South Africa, but the Court has generally preferred the English reasonableness test to the core health services doctrine advocated by its Columbian and Indian counterparts. In this way, the CCSA has maintained its restrictive approach to the right to health, with the *TAC* case being one notable exception.

CONCLUSION

As we have seen, countries with a direct constitutional guarantee to the right to health tend to provide the strongest opportunity to enforce the right. These countries, however, depend on the approach of the judiciary to enforcing the right, as the South African cases demonstrate.

By comparison, some countries without a constitutional right to health have judicially found the right to be encompassed by other constitutional rights, in the way that India's right to life has been utilised in the field of health. Additionally, though less successfully, some judiciaries have introduced a right to health by considering or implementing international instruments.

The question arises, could a right to health be realistically enforced in Australia? Its Constitution does not contain a direct right to health and, unlike the constitutions of countries such as India, Australia's Constitution does not include a right to life from which to draw a right to health.

It follows that the only theoretical means currently available for Australian courts is to read in the obligations it has undertaken via international instruments. Australia is a signatory to international treaties protecting the right to health, predominantly the *ICESCR*. But Australia has not yet ratified the Optional Protocol to the *ICESCR*,¹¹⁶ which outlines procedures by which individual communications may be made seeking redress for a breach of the Covenant.¹¹⁷ This lack of ratification renders the Protocol irrelevant.

¹¹⁶ See <http://www.hrlc.org.au/optional-protocol-to-icescr-enters-into-force> [accessed 4 September 2013].

¹¹⁷The text of the Optional Protocol may be found at http://www.ohchr.org/Documents/Press/OP_ICESCR.pdf [accessed 4 September 2013].

Australian courts have long accepted the constitutional position that, while Australia's international obligations may be relevant to interpretation of legislation¹¹⁸ and may assist in the development of common law in certain circumstances,¹¹⁹ treaty obligations do not override existing law unless they have been legislated by the Parliament into domestic law.¹²⁰

Justice Kirby stated in *Kartinyeri v Commonwealth*¹²¹ that clear constitutional provisions cannot be overridden by any of Australia's international obligations including customary law. Therefore, if a constitutional provision is clear and a law is within its power, no rule of international law or treaty may override the Constitution or any law validly made under it, or restrict the ability of the Parliament to make that law.¹²²

The *Kartinyeri* case considered the plan of commercial developers to build a bridge in an area protected under the *Aboriginal and Torres Strait Islander Heritage Protection Act 1994* (Cth) (*Heritage Protection Act*). To allow work on the bridge to commence, the Commonwealth government passed the *Hindmarsh Island Bridge Act 1997* (Cth) to invalidate part of the *Heritage Protection Act*. The majority judgment held that Australia's international obligations would not be permitted to interfere with this selective statutory infringement upon the rights of the indigenous population in the area.

The joint opinion of Gummow and Hayne JJ in the majority stated:

It has been accepted that a statute of the Commonwealth or of a State is to be interpreted and applied, as far as its language permits, so that it is in conformity and not in conflict with the established rules of international law. On the other hand, the provisions of such a law must be applied and enforced even if they be in contravention of accepted principles of international law.¹²³

Kirby J said in dissent:

¹¹⁸ See *Al-Kateb v Godwin* (2004) 219 CLR 562 at 591.

¹¹⁹ *Mabo v Queensland (no. 2)* (1992) 175 CLR 1, 42, per Brennan J. and *Dietrich v The Queen* [1992] 177 CLR 292, 305-6

¹²⁰ The *Racial Discrimination Act 1975* (Commonwealth) is an example of legislation of that kind as is *Human Rights (Sexual Conduct) Act 1994*.

¹²¹ 195 CLR 337, paras 98-100. Kirby cited two cases: *Polites v The Commonwealth* (1945) 70 CLR 60; *Horta v The Commonwealth* (1994) 181 CLR 183.

¹²² *Polites v The Commonwealth* (1945) 70 CLR 60 at 69, 79; *Horta v The Commonwealth* (1994) 181 CLR 183 195.

¹²³ [1998] HCA 22, paragraph 97. See also *Polites v The Commonwealth* (1945) 70 CLR 60 at 68-69, 77, 80-81; *Minister for Immigration and Ethnic Affairs v Teob* (1995) 183 CLR 273, paragraph 287.

Where there is ambiguity in the common law or a statute, it is legitimate to have regard to international law. Likewise, the Australian Constitution, which is a special statute, does not operate in a vacuum. It speaks to the people of Australia. But it also speaks to the international community as the basic law of the Australian nation which is a member of that community.¹²⁴

His Honour's view in *Kartinyeri* was consistent with his statement in the earlier case of *Newcrest Mining v The Commonwealth*.

Where the Constitution is ambiguous, this Court should adopt that meaning which conforms to the principles of universal and fundamental rights rather than an interpretation which would involve a departure from such rights.¹²⁵

The 2007 case of *Roach v Electoral Commissioner*¹²⁶ considered a statute to deprive all prisoners of the right to vote. The statute was declared invalid by the High Court as an unreasonable breach of human rights. Central to the decision, however, was that the broad scale deprivation of the right of prisoners to vote was found to be a disproportionate response to the provision for representative democracy in the Constitution itself.¹²⁷

The High Court has yet to face the question of whether parliamentary supremacy can be overridden by the international treaties that Australia has agreed to follow. In other words, the High Court has never faced a *Factortame* scenario.

On the other hand, the Australian judiciary, unlike the English Courts, has faced indigenous claims of native title, conflicting with the then established doctrine of terra nullius. When the High Court established the validity of native title in *Mabo v Queensland (No. 2)*,¹²⁸ it boldly created – or re-discovered – a legal entity not found in the statute books. The Court took into consideration developments in other countries where similar native title claims had been made, and the *ICCPR* and the system permitting communications to be made to a UN Committee for adjudication.¹²⁹

¹²⁴ Ibid paragraph 166.

¹²⁵ (1997) 71 ALJR 1346 1423; 147 ALR 42, paragraph 147.

¹²⁶ [2007] HCA 43.

¹²⁷ Ibid paragraph 23 per Gleeson C.J. and paragraphs 85-95 per Gummow, Kirby and Crennan JJ.

¹²⁸ (1992) 175 CLR 1.

¹²⁹ Ibid 42.

As human rights lawyer Stephen Keim SC describes the current situation, ambiguities, uncertainty and lacunae are necessary for international human rights principles to exert their legitimate influence on the development of Australia's unwritten law.¹³⁰

We conclude that, as there is no constitutional or statutory impediment to a judicialisation of claims for an individually enforceable right to health, a claim based upon Australia's international obligations could be possible. Such a step would require, from the courts, an incursion into hitherto uncharted territory, similar to the approach taken in *Mabo*. The case law presented in this article shows that courts in other countries have veered in this direction. Certainly, as the lung transplant case related in our introduction shows, the USA has taken this step without any relevant provision in their constitution or statutes. Why should Australia lag behind in the implementation of such a crucial human right as the right to health?

¹³⁰ Keim, Stephen, *What Does a Human Rights Lawyer Do?* A paper presented at a Cambridge University Press seminar, 31 July 2013.

http://www.academia.edu/4234010/What_Does_a_Human_Rights_Lawyer_Do, [accessed 24 August 2013], citing *Dietrich v The Queen* [1992] 177 CLR 292, 305-6. See also the discussion of *Mabo* in this paper.