

Inter-Regional Conference on Human Rights and Judiciary Systems:

Brasilia 18-20 September 2006

Working Group VI. The Right to Health

Iain Byrne, Presenter.

Senior Lawyer, Commonwealth Programme, Interights

Visiting Fellow, Human Rights Centre, Essex University

Summary

This paper aims to (a) analyse how courts in South Africa, India, some Latin American and post Soviet jurisdictions, together with the UK and some other common law jurisdictions,, with different legal frameworks for protecting economic and social rights have approached right to health issues, including access to medicines and treatment, discrimination on the basis of HIV and environmental pollution and (b) what lessons can be learned for effective implementation.

Introduction

This paper seeks to examine how courts from a variety of jurisdictions have approached healthcare and treatment issues and the innovative methods they have employed for both adjudication and enforcement. The non exhaustive survey of case law is divided into two main sections – those jurisdictions where (a) the right to health is expressly protected in domestic law, usually as part of a constitutional bill of rights and (b) protection is less explicit but has to be implied often through creative interpretation of existing fundamental guarantees.

The UN Committee on Economic, Social and Cultural Rights in its General Comment 9 has emphasised that it is up to states how they give effect to the rights contained in the

International Covenant on Economic, Social and Cultural Rights (ICESCR), including the right to health, but whatever arrangements they choose they must be effective :

“..[T]he central obligation in relation to the Covenant is for States parties to give effect to the rights recognized therein. By requiring Governments to do so "by all appropriate means," the Covenant adopts a broad and flexible approach which enables the particularities of the legal and administrative systems of each State, as well as other relevant considerations, to be taken into account. But this flexibility coexists with the obligation upon each State party to use all the means at its disposal to give effect to the rights recognized in the Covenant. In this respect, the fundamental requirements of international human rights law must be borne in mind. Thus the Covenant norms must be recognized in appropriate ways within the domestic legal order, appropriate means of redress, or remedies must be available to any aggrieved individual or group, and appropriate means of ensuring governmental accountability must be put in place.” [Paras 1 and 2]

Hence whether states automatically incorporate the ICESCR and other international human rights treaties upon ratification as most civil law countries, including those in Latin America, do, or pass specific enabling legislation, as in the case of the UK (although it has only done this to date in the case of the European Convention of Human Rights) or opt for non-ratification but adopt a progressive constitution which contains broadly similar guarantees, as in the case of South Africa, the role of the courts is vital in ensuring that liberal and purposive interpretations are given to both express and implied guarantees.

Both states and the international community have tended to pay lip service to the principle that all rights are of equal status, indivisible and interdependent, as elaborated in instruments such as the Universal Declaration of Human Rights and the Vienna Declaration and Programme of Action¹, with economic, social and cultural rights often

¹ Article 5 of the Vienna Declaration states: ‘All human rights are universal, indivisible, interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner on

regarded (at least in the developed world) as the poor cousin of their civil and political counterparts². Yet it is self-evident that the right to health has clear links to many other rights, both civil and political – e.g. rights to life, not to be subjected to torture or cruel, inhuman or degrading treatment and to information – or economic and social – e.g. rights to food, environment, housing, work and education. This can be seen both in the impact the denial or enjoyment of other rights can have on a person’s ability to achieve the highest attainable standard of physical and mental health³ and, conversely, the role health plays in our enjoyment of other rights – an unhealthy citizen is not able to play a full and active part in society either economically or politically.

Traditionally, health issues when they reach the courts (particularly in those jurisdictions where there is no explicit guarantee to the right to health) have tended to be dealt with from a negative civil liberties perspective rather than consideration of the positive state obligations to provide adequate resources or access to treatment for effective enjoyment. This is particularly the case in relation to mental health where judgments have tended to focus on the restrictions placed on patients rather than their right to adequate treatment. There have been some rare forays by tribunals into examining positive aspects but often the analysis is limited⁴.

the same footing, and with the same emphasis. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of the States, regardless of their political, economic and cultural systems to promote and protect all human rights and fundamental freedoms.’

² This is reflected in the disproportionate amount of resources devoted to civil and political rights by the UN human rights machinery, an imbalance that has only begun to be addressed during the last decade.

³ The formula used by Article 12 of the International Covenant on Economic, Social and Cultural Rights which states: ‘1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.’

⁴ See *Moore v Gambia* (241/2001) in which the African Commission on Human and Peoples Rights stated that the state was under an obligation to realise the right to health of mental health patients to the maximum of available resources but did not elaborate beyond this.

How far judges should be prepared to go in deciding questions with resource implications – something which does not just effect the right to health but clearly all economic and social rights (esrs) – is a crucial question whether rights are codified or not. Certainly, violations of esrs are easier to identify and remedy when state obligations relate to respecting and protecting rights - the lower end of the typology framework used by the UN Economic, Social and Cultural Rights Committee and other experts – rather than at the more contentious provision or fulfilment stage⁵. Where claims are sought in relation to the latter, one leading commentator on the right to health has noted that they will be most likely to be successful where the obligations relate to clearly defined rights of access to health-related services⁶.

Express protection of the right to health in domestic law – enhanced protection but still problematic

Chile provided the first constitutional recognition of the right to health as far back as 1925. Subsequent constitutional provisions have taken various forms with clauses elaborating amongst others (i) a right to general well-being (e.g. South Africa⁷ where the guarantee is part of a provision requiring access to health care services, food and water

⁵ For a fuller exposition of state obligations in relation to the right to health under the ICESCR see General Comment 14 on The Right to the Highest Attainable Standard of Health by the UN Committee on Economic, Social and Cultural Rights (E/C.12/2000/4)

⁶ Brigit Toebes 'The Right to Health' in Eide, Krause and Rosas, *Economic, Social and Cultural Rights : A Textbook* (Martinus Nijhoff 2001) p184. Toebes cites a decision of the Dutch Central Appeals Court in 1996 holding that ILO Convention 102 on right to a certain medical benefit in a hospital did have direct effect and was self-executing because the services were closely circumscribed and the provisions were imperative in nature.

⁷ Article 27 of the South African Constitution provides : '(1) Everyone has the right to have access to (a) health care services, including reproductive health care; (b) sufficient food and water; and (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance. (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. (3) No one may be refused emergency medical treatment.'

and social security (see further below) and similarly in Finland⁸); (ii) a right to free medical services (e.g. Guyana⁹) (iii) a right to a healthy environment (e.g. Hungary¹⁰) (iv) a right to enjoy the highest possible level of physical and mental health (e.g. Hungary¹¹); (v) a direct relationship to right to the life (e.g. Haiti¹²) ; (vi) specific state obligations (e.g. Netherlands¹³ and Haiti¹⁴) and (vii) Directive Principles of State Policy (DPSP) (e.g. India¹⁵, Philippines¹⁶, Malawi¹⁷, Uganda¹⁸ and Ghana¹⁹).

⁸ Section 19 of the Finnish Constitution provides: ‘(1) Those who cannot obtain the means necessary for a life of dignity have the right to receive indispensable subsistence and care. (2) Everyone shall be guaranteed by an Act the right to basic subsistence in the event of unemployment, illness, and disability and during old age as well as at the birth of a child or the loss of a provider. (3) The public authorities shall guarantee for everyone, as provided in more detail by an Act, adequate social, health and medical services and promote the health of the population. Moreover, the public authorities shall support families and others responsible for providing for children so that they have the ability to ensure the well-being and personal development of the children.(4) The public authorities shall promote the right of everyone to housing and the opportunity to arrange their own housing.’

⁹ Article 25 of the Guyana Constitution provides: ‘Every citizen has the right to free medical attention and also to social care in case of old age and disability.’

¹⁰ Article 18 of the Hungarian Constitution provides: ‘The Republic of Hungary recognizes and shall implement the individual's right to a healthy environment.’

¹¹ Article 70D of the Hungarian Constitution provides: ‘(1) Everyone living in the territory of the Republic of Hungary has the right to the highest possible level of physical and mental health. (2) The Republic of Hungary shall implement this right through institutions of labor safety and health care, through the organization of medical care and the opportunities for regular physical activity, as well as through the protection of the urban and natural environment.’

¹² Article 19 of the Haitian Constitution provides : ‘The State has the absolute obligation to guarantee the right to life, health, and respect of the human person for all citizens without distinction, in conformity with the Universal Declaration of the Rights of Man.’

¹³ Article 22 of the Dutch Constitution provides : ‘(1) The authorities shall take steps to promote the health of the population. (2) It shall be the concern of the authorities to provide sufficient living accommodation. (3) The authorities shall promote social and cultural development and leisure activities.’

¹⁴ Article 23 of the Haitian Constitution provides : ‘The State has the obligation to ensure for all citizens in all territorial divisions appropriate means to ensure protection, maintenance and restoration of their health by establishing hospitals, health centers and dispensaries.’

¹⁵ Article 47 of the Indian Constitution provides : ‘Duty of the State to raise the level of nutrition and the standard of living and to improve public health.- The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavor to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health.’

¹⁶ Article 13 of the Filipino Constitution provides: Social Justice and Human Rights: Section 1. The Congress shall give highest priority to the enactment of measures that protect and enhance the right of all the people to human dignity, reduce social, economic, and political inequalities, and remove cultural inequities by equitably diffusing wealth and political power for the common good. To this end, the State shall regulate the acquisition, ownership, use, and disposition of property and its increments. Section 2. The promotion of social justice shall include the commitment to create economic opportunities based on freedom of initiative and self-reliance.’

It is interesting to note that many of the developed economies in the common law system, e.g. UK, Australia, Canada, New Zealand, do not provide for any explicit recognition of health rights whilst African and South Asian countries do (albeit often by way of DPSP although, as will be shown below, this is not a bar to judicial recognition and enforcement). This divide reflects the geo-political context of the post World War II world where Western and Western influenced states tended to favour civil and political rights over esrs whilst those states more closely allied to the Soviet bloc, or non-aligned in the case of India, and engaged in colonial independence struggles took an opposite view point. The end of the Cold War and increasing recognition, not least amongst jurists, that both sets of rights are interconnected and of equal value have provided new

¹⁷ Article 13(2) of the Malawian Constitution provides : ‘The State shall actively promote the welfare and development of the people of Malawi by progressively adopting and implementing policies and legislation aimed at achieving the following goals....To provide adequate health care, commensurate with the health needs of Malawian society and international standards of health care.’

¹⁸ Article 14 of the Ugandan Constitution provides: ‘General Social and Economic Objectives: The State shall endeavour to fulfill the fundamental rights of all Ugandans to social justice and economic development and shall, in particular, ensure that-(i) all developmental efforts are directed at ensuring the minimum social and cultural well-being of the people; and (ii) all Ugandans enjoy rights and opportunities and access to education, health services, clean and safe water, work. decent shelter, adequate clothing, food security and pension and retirement benefits.’

¹⁹ Article 34 of the Ghana Constitution provides: (1) The Directive Principles of State Policy contained in this Chapter shall guide all citizens, Parliament, the President, the Judiciary, the Council of State, the Cabinet, political parties and other bodies and persons in applying or interpreting this Constitution or any other law and in taking and implementing any policy decisions, for the establishment of a just and free society. (2) The President shall report to Parliament at least once a year all the steps taken to ensure the realization of the policy objectives contained in this Chapter and, in particular, the realization of basic human rights, a healthy economy, the right to work, the right to good health care and the right to education.

avenues of legal protection, particularly in the case of esrs such as the right to health. The remainder of this paper seeks to explore some of these developments and what lessons can be learned for future litigation strategies.

The South African Experience

Of those countries that do provide constitutional recognition of a right to health and other esrs, arguably one of the best known and most widely celebrated is South Africa reflecting the values of the pluralist, egalitarian and democratic state that replaced apartheid in 1994. However, it should be noted that although esrs are a prominent feature of the Constitution these were not included without a struggle²⁰ and significant cases to date amount to no more than half a dozen. Esrs are divided into three broad categories : (a) basic rights with no qualification on implementation covering children's rights, basic education for everyone including adults and rights of detainees; (b) access rights covering the main guarantees to adequate housing, food, water, social security, and health care based on progressive realization according to available resources (a similar formulation to Article 2(1)²¹ of the International Covenant on Economic, Social and Cultural Rights (ICESCR) although South Africa has yet to ratify it) and (c) prohibition on certain negative actions by the state including forced evictions and refusal of emergency medical treatment.

The specific provision protecting health rights is Article 27 which provides (as part of a general well being provision similar in formulation to Article 25 of the Universal Declaration of Human Rights and s 19 of the Finnish Constitution) that : “(1) Everyone has the right to have access to (a) health care services, including reproductive health care; (b) sufficient food and water; and (c) social security, including, if they are unable to

²⁰ See Pierre De Vos ‘Pious Wishes or Directly Enforceable Human Rights? Social and Economic Rights in South Africa's 1996 Constitution’ *South African Journal on Human Rights* Vol 13 p 67 (1997)

²¹ Article 2(1) provides: ‘Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.’

support themselves and their dependants, appropriate social assistance. (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. (3) No one may be refused emergency medical treatment.’

Health rights, together with housing rights, have provided the most significant constitutional esrs cases considered by the South African courts to date and this paper considers three of them. In *Soobramoney v Minister of Health KwaZulu Natal* 1997 (12) BCLR 1696 the Constitutional Court was faced with not merely one of its first esrs cases but potentially difficult moral questions to consider. S had chronic kidney failure which was terminal. However, costly dialysis treatment would have prolonged his life for a short period, but the local health authority refused it on the grounds of lack of resources. In his claim S relied on s 27(3) protecting the right to emergency medical treatment construed with the right to life as guaranteeing him a right to cost free medical treatment. Distinguishing the Indian case of *Paschim Banga Khet Mazdoor Samity & Ors v State of West Bengal* 1996 AIR SC 2426²² (see further below) the Court held there was no need to infer a right to medical treatment from the right to life since it was directly protected by s 27. However, it went on to rule that a request for ongoing treatment could not come under emergency medical care and therefore the case fell to be decided under the access to medical services provisions. On this point the Court found no breach since, within the context of the limited resources available, the health authority had acted reasonably and applied its guidelines rationally and fairly in the case of S given (a) the expensive nature of the treatment and (b) the fact that it would only have prolonged S’s life for a short period. For the Court this has been the crucial test in considering all esrs claims – has the State done all it could reasonably do in the circumstances ?²³ By adopting this approach the Court has recognized that it is not in a position to assume the role of the state in making decisions about resource allocation but is instead there to act as an impartial arbiter. This process is similar in format to judicial review although will often extend

²² By distinguishing the West Bengal case it raises the question whether faced with the Indian situation of refusal of emergency medical treatment the Constitutional Court would have restricted itself to dealing with the particular situation faced by the victim or would have attempted to lay down a policy for compliance with the constitutional principle as the Indian Supreme Court sought to do.

²³ See the landmark decision of *Government of RSA v Grootboom* 2000 (11) BCLR 1169 (CC)

beyond the decision-making process to examine all the actions taken by the state. Indeed in *Soobramoney* the Court was very explicit about the large margin of discretion it would give to the state to set budgetary priorities stating that the court “*will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities*” [para 29]. Sachs J went further stating that : “*In open and democratic societies based upon dignity, freedom and equality, the rationing of access to life-prolonging resources is regarded as integral to, rather than incompatible with, a human rights approach to health care*” [para 52]. To admit S’s case would have been to open the floodgates to other claimants in a similar position placing an unbearable strain on medical resources²⁴.

The second significant health case considered by the Constitutional Court and one of the most widely known due to the issues involved is *Minister of Health v Treatment Action Campaign (TAC)* (2002) 5 SA 721 (CC) or the TAC case. The Court was required to determine whether the state’s failure to provide comprehensive anti-retroviral drugs to prevent mother-child HIV transmission constituted a breach of Article 27(1). The state argued that the drugs could only be distributed through a few centres designated for research which were able to provide the necessary complementary services such as counselling, new obstetric practices and education of mothers in alternative to breast feeding. The Court held that whilst research was important this was not a sufficiently good reason for delay in rolling out the programme to other centres: “*This does not mean....that until the best programme has been formulated and the necessary funds and infrastructure provided for the implementation...the drug must be withheld from mothers and children who do not have access to the research and training sites. Nor can it reasonably be withheld until medical research has been completed*” [para 68].

An important factor for the Court was the fact the drug (unlike the treatment in *Soobramoney*) was costless to the government and therefore arguments centered on lack of resources did not carry any weight. However, by requiring that the programme should

²⁴ See also the approach of the New Zealand Court of Appeal in *Shortland v Northland Health* [1998] 1 NZLR 433 examined below.

include reasonable measures for counselling and testing, the Court did make orders with some (albeit limited) financial implications. Beyond this and unlike the approach often taken by the Indian Supreme Court and the Inter-American Court of Human Rights, the Court refrained from discussing detailed modes of implementation. Arguably, this created subsequent problems regarding the implementation of the judgment since it took several months of campaigning and lobbying by TAC and others to force the authorities to act and start supplying the drugs. The lessons from the TAC case demonstrate that obtaining a positive judgment, particularly in relation to esrs is only half the story, and that ensuring effective implementation is often a greater challenge.

The third case, *B & Ors v Minister of Correctional Services* [1997] ICHRL 37, considered by the High Court, also concerned the supply of anti-retroviral drugs and whether they should be provided to HIV prisoners at the state's expense. The Court, in finding a breach of a prisoner's right to adequate medical care under s 35(2) of the Constitution, held that given this guarantee is not a right provided to people outside prison, the latter should not be an absolute standard for what is adequate for prisoners. The Court recognised that unlike free persons, prisoners have no access to other resources to gain medical treatment and that HIV positive prisoners are more exposed to opportunistic viruses because of overcrowded accommodation. In these circumstances the extension of life expectancy and enhanced quality of life provided by anti-viral therapy required the treatment to be provided to sufferers of HIV if at all affordable. In particular, the Court held that where anti-viral therapy has been prescribed to a prisoner on medical grounds then it should be provided at the state's expense and failure to do so amounted to an infringement of Article 35(2).

However, the Court also continued to proscribe the limits of the judiciary's role in health cases by stating that whether the applicants and other HIV patients who fell within certain grounds were entitled to a prescription of a particular combination of anti-viral treatments was a medical question and it was not the court's function to make an order dictating to doctors when they must prescribe anti-viral treatment without discretion. Moreover, it recognised that in deciding what 'adequate medical treatment' constituted in terms of s 35(2) the court could and should be aware of budgetary constraints.

The cautious approach of the South African courts in relation to esrs contrasts with the more assertive stance of their Indian brethren who over a much longer period have frequently been willing to actively intervene in policy and administrative areas usually viewed as the preserve of the executive, handing down detailed orders often with significant resource implications (see further below) . Critics of the Indian approach have pointed to the lack of cooperation it has apparently engendered in state officials requiring, on occasion, contempt of court proceedings to be initiated. However, the TAC case illustrates that the South African Constitutional Court cannot rely on the goodwill of officials to implement its decisions and may also have to be more proactive in monitoring and enforcement whilst continuing to walk a fine line in preserving the separation of powers.

The Latin American experience

Three cases from Latin America deal with similar problems explored in the TAC case concerning inadequate state responses to pandemic diseases. One of the leading decisions is *Mariela Viceconte v Ministry of Health and Social Welfare* Case No 31.777/96 (1998) from Argentina in 1998²⁵. The claim was brought by a number of community groups to ensure that the state would manufacture a vaccine against Argentine hemorrhagic fever, threatening the lives of 3.5 million people, most of whom did not adequate access to preventive medical services, in certain affected areas. Whilst the state had been able to

²⁵ For a further discussion of the case see Abramovich ' Argentina : The Right to Medicines' in *Litigating Economic, Social and Cultural Rights : Achievements, Challenges and Strategies* (COHRE 2003)

obtain 200,000 doses of a vaccine from the United States and vaccinate 140,000 people between 1991 to 1995 it was unable to carry out a massive immunisation campaign due to the lack of an adequate quantity. A judicial writ of amparo (a constitutional remedy providing individual relief) was filed requiring the health ministry to manufacture and distribute further supplies of the vaccine to persons living in the affected areas. Following initial rejection the Court of Appeals ruled favourably establishing the state's obligation to manufacture the vaccine. Significantly (and unlike in South Africa) the court also set a legally binding deadline for the obligation to be met. In reaching its judgment the court drew on regional and international human rights standards, including the American Declaration on the Rights and Duties of Man, the UDHR, but particularly the right to health under Article 12 of ICESCR, all of the instruments having been incorporated into the domestic law in Argentina and considered to form part of the Constitution. This was in direct response to the petitioners' assertion that where a state is facing a major health problem threatening significant numbers of lives the legal obligation under Article 12 of the ICESCR is particularly strong.

As in the TAC case, it required further action by the groups, including litigation, to secure enforcement. Nevertheless, the case is seen as important for a number of reasons. It reaffirmed the judicial process as a method for enabling ordinary citizens to challenge state agencies regarding the merit of health policies, saw the direct application by a domestic court of international standards on the right to health thereby expanding the scope for further realization of esrs; imposed personal responsibility on two ministers for the manufacture of the vaccine with a specific deadline thereby demonstrating that the obligations arising from esrs are legal in nature and entail legal liabilities and affirmed the role of the state as guarantor of the right to health in the event that the private sector is unable or (more likely) unwilling to provide the necessary services. Ultimately cases such as *Mariela Viceconte* can have a political as well as legal impact far beyond that perhaps envisaged when the original petition was submitted. Within five years Argentina had developed a social plan to deliver basic medicines the roots of which can be directly traced to the *Viceconte* case.

A case concerning HIV is *Mendoza & Ors v Ministry of Public Health* Resn No 0749-2003-RA (28 Jan 2004) from Ecuador where the Constitutional Court held that Ministry of Health had failed in its obligation under Article 42 of the Constitution to protect the right to health by suspending a HIV treatment programme. Again, in upholding the right to health, references were made to relevant international standards including Article 11 of the American Declaration on the Rights and Duties of Man and Article 10 of the San Salvador Protocol. The Court also held that although right to health is an autonomous right it also forms part of the right to life echoing the approach of the Indian Supreme Court (see the *West Bengal* case below). In so doing it envisaged that a right to health entitled citizens not only to take legal action for the adoption of policies and plans related to general health protection but also to demand that appropriate laws be enacted and that the Government provide the necessary resources. Whilst such a judgment might be seen as having enormous implications for the executive it provides the measure of accountability necessary to achieve effective implementation of the right to health.

Post Soviet jurisdictions

In Central and Eastern Europe the legacy of the Soviet system where priority was given to economic and social rights over civil and political freedoms has not only resulted in a number of constitutions expressly recognising the right to health, but also Constitutional Courts adopting a more collective approach, e.g. in both Hungary and Poland the courts have interpreted right to health (or free health care) as non-individual rights satisfied by the provision of public services by the state. The Hungarian Constitutional Court has been particularly vigorous, adopting a 'ratchet' approach which recognises a state duty to maintain the level of services (e.g. welfare benefits, number of patient beds) even during economic austerity. The result is that once a certain level of protection is provided under statute it cannot be repealed or diminished by a subsequent law²⁶. Compare this approach to the UK where economic and social rights have tended to be subject to the vagaries of the government of the day unless the courts are prepared to indirectly protect healthcare

²⁶ Some have criticised this approach as being too interventionist but there is no evidence that the Court's judgments hindered the transition of Hungary to a more mixed economy during the 1990s. See Schepele 'A Realpolitik Defense of Social Rights' 82 *Tex Law Review* 1921 (2004)

rights through innovative application of the European Convention on Human Rights standards (see further below). The Hungarian approach is more in line with the ‘progressive realisation’ of the ICESCR, although this was not explicitly mentioned by the Constitutional Court which based its argument instead on the principle of legal certainty which respected vested rights and recognised legitimate expectations²⁷.

Non-codification – the need to adopt innovative approaches

The lack of express constitutional protection for health rights provides courts, lawyers and activists with significant but not insurmountable challenges for enforcement. Much will depend upon how far courts will be prepared to go in offering creative but legitimate approaches which do not exceed the scope of judicial powers.

Techniques include : (a) adopting expansive definitions of civil rights some of which tend to be widely if not universally guaranteed under domestic law, e.g. rights to life or not be subjected to cruel, inhuman or degrading treatment. This approach has been sanctioned to differing degrees by both the UN Human Rights Committee and the European Court of Human Rights²⁸. The former in its General Comment Number 6 para 5 on the right to life stated : *“the right to life has been too often narrowly interpreted. The expression “inherent right to life” cannot properly be understood in a restrictive manner, and the protection of this right requires that States adopt positive measures. In this connection, the Committee considers that it would be desirable for States parties to take all possible measures to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics.”* Indeed, as the previous comment makes clear that the Committee was explicitly considering health issues in adopting a more liberal interpretation of the right to life; (b) considering the due process issues by exercising some form of judicial review. This has tended to be the approach adopted by the British courts in the absence of any express constitutional protection but

²⁷ In this respect the Hungarian Court adopts a similar approach to the European Court of Justice.

²⁸ In the case of *Osman v UK* (2000) 29 EHRR 245 the Court recognised the positive obligations on the state to protect the right to life (in this case the police in relation to threats to the victim made by another individual) leading some to conclude that this could be extended to economic and social rights although this has yet to be tested.

suffers from the fact that only the reasonableness of the decision-making process itself is considered rather than the substance of the right although it may still allow for some indirect protection of esrs (c) use of cross-cutting provisions such as equality and non-discrimination which, again, may not allow for consideration of the substantial economic or social right but at least afford some measure of indirect protection.

The Indian story: activism and innovation

Although South Africa has tended to attract much of the attention amongst Commonwealth jurisdictions for its protection of economic and social rights Indian courts have been at the forefront of esrs litigation for over three decades. The Indian Constitution, promulgated in 1947, is a creature of its age and on its face far less progressive than its South African counterpart from the mid 1990s. Economic and social rights, including the right to health contained in Article 47²⁹ (as in a number of other Constitutions such as the Philippines, Ghana and Uganda) are consigned to the Directive Principles of State Policy (DPSP) section. According to Article 37 of the Constitution DPSP “*shall not be enforceable by any court, but the principles therein laid down are nevertheless fundamental in the governance of the country and it shall be the duty of the state to apply these principles in making laws.*”

Therefore on its face the Supreme Court is barred from considering and enforcing individual health rights claims but rather is concerned with offering non-binding guidelines on how health policies should be implemented whilst leaving the final decision to the state. However, the early 1970s witnessed a watershed in Indian human rights litigation with the *Fundamental Rights Case*³⁰ ushering in an unprecedented period of progressive jurisprudence following the recognition by the Court that DPSP should enjoy the same status as ‘traditional’ fundamental rights. At the same time standing rules were

²⁹ Supra n.15

³⁰ *Keshavananda Bharati v. State of Kerala* (1973) 4 SCC 225

relaxed in order to promote public interest litigation and access to justice. Suddenly writ petitions could be submitted on a postcard³¹.

The main means by which the Supreme Court has achieved equivalence between civil rights and their economic and social counterparts has been through the application of an expansive definition of the right to life. Unsurprisingly the right to health was one of the guarantees to first benefit from this approach³². To date one of the most significant right to health decisions has been the public interest litigation case of *Paschim Banag Khet Samity v State of West Bengal* (1996) 4 SCC 37 where the Supreme Court used the right to life to secure the right to emergency medical care concluding that such an essential obligation could not be avoided by pleading financial constraints. The petitioner had been taken to a succession of eight state medical institutions ranging from a local health centre to two medical colleges and was refused treatment at each either due to lack of beds or lack of technical capacity. Eventually he was admitted to a private hospital where he was treated at a cost of Rs. 17,000. The Court, in holding that there had been a violation of the right to life under Article 21 and awarding compensation, stated that the right to emergency medical care formed a core component of the right to health which in turn was recognised as forming an integral part of the right to life. It did this by reconceptualizing the right to life as imposing a positive obligation on the state to safeguard the life of every person stating that “*preservation of human life was of utmost importance*” and that:

“The Constitution envisages the establishment of a welfare state...Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the government in this respect and discharges this obligation by running hospitals and health centres...”

³¹ For a good overview of the Indian courts’ approach to esrs see S. Muralidhar ‘Justiciability of Economic and Social Rights – The Indian Experience’ in *Circle of Rights* (IHRP 2000)

³² See *Francis Coralie Mullin v. The Administrator, Union Territory of Delhi* (1981) 2 SCR 516 concerning detention conditions and *Parmanand Katara v. Union of India* (1989) 4 SCC 286 regarding obligation of state to provide emergency medical treatment.

In line with its general approach of frequently offering comprehensive remedies that go beyond merely providing redress for the victim but also lay down the necessary policy and administrative steps to be taken by the state in the wider public interest, the Court not only ordered compensation, but also directed the type of facilities that the state government had to provide. This included hospitals and emergency provision (ambulances and communications) by formulating a blueprint for primary health care with particular reference to treatment of patients under an emergency as part of the state's public health obligation under Article 47. Furthermore, the Court ruled that its orders should apply to other states, together with the national government, and that they should be sent a copy of the judgment.

However, in *Consumer Education and Research Centre v. Union of India* (1995) 3 SCC 42 the Court recognised that state resources are not limited and that no breach of the Constitution was incurred by reducing some employees' entitlements to medical benefits :

“No State or country can have unlimited resources to spend on any of its projects. That is why it only approves its projects to the extent it is feasible. The same holds good for providing medical facilities to its citizens including its employees. Provision on facilities cannot be unlimited. It has to be to the extent finances permit. If no scale or rate is fixed then in case private clinics or hospitals increase their rate to exorbitant scales, the State would be bound to reimburse the same. ”

During the last two decades the Court has considered many public interest litigation cases involving protection of the environment, many of them brought by lawyer and activist, M C Mehta. These cases not only demonstrate the links between environmental rights and rights to health and to life, but also demonstrate how active the Supreme Court is prepared to be on occasion to secure protection of esrs. In *Mehta v Union of India* (1999) 6 SCC 9 the Supreme Court, after appointing an expert committee to formulate a detailed policy on conversion from petrol to cleaner fuels for vehicles in heavily polluted Delhi

and incorporating its recommendations, issued several time-bound directions for conversion. However, the Court had to contend with the charge that these orders were inconsistent with existing statutes and that it was illegitimately extending its jurisdiction into an area of competence normally reserved for the executive. The Court responded that the directions were necessary to safeguard people's right to health and therefore should trump statutory provisions. Hence in exercising its mandate as the guardian of constitutional rights, the Court made clear that the public health considerations were clearly significant enough to justify taking a major policy decision rather than a stricter adherence to separation of powers

This activist approach has had an impact beyond India's own borders to other countries in the South Asian region who have also framed esrs under DPSP. In *Dr Mohiuddin Farooque v Bangladesh & Ors (No 1)* 48 DLR (1996) HCD 438 the Bangladeshi Supreme Court, upon finding that a consignment of powdered milk imported by a company exhibited a radiation level above the acceptable limit in some (but not all) of the examinations conducted by various government testing bodies, upheld the claim that the actions of government officers in not compelling the importer to send the consignment back to the exporter had violated the constitutional right to life of people who were potential consumers. The Court noted that the right to life is not limited to the protection of life and limb necessary for the full enjoyment of life but also includes, amongst other things, the protection of the health and normal longevity of an ordinary human being and that if this was threatened by a man made hazard then the state could be compelled by the court to remove the threat (unless justified by law) even where its primary DPSP obligation under Art 18 to raise the level of nutrition and improve public health could not be enforced. Hence, as in the Indian cases, the Court was recognizing that artificial divisions between 'Fundamental Rights' and DPSP provisions should not prevent it acting to safeguard public health.

Creative approaches from other common law jurisdictions

Canada has no express provision protecting the right to health in its Charter of Rights and Fundamental Freedoms. Yet this has not prevented the Supreme Court from indirectly offering protection to the right by using other provisions. In particular, the equality provision under Article 15 has been used to protect persons on the basis that similar treatment may not always guarantee substantive equality in order in the words of former Supreme Court Justice L'Heureux Dube to achieve a “*contextual and empathetic approach to ensuring each person’s human dignity*”³³. In this context the Court has ruled that whilst s 15 does not impose upon governments the obligation to take positive actions to remedy the symptoms of systematic inequality, it does require that the government should not be a further source of inequality. The main health care case to date is *Eldridge v British Columbia* [1997] 3 SCR 624 which involved deaf individuals challenging the failure of a provincial government to provide sign-language interpreters as part of its publicly funded healthcare system. The Court held that this constituted discrimination on the basis that government should ensure that in providing general benefits to the population they should guarantee that disadvantaged members of society have the resources to take full advantage of these benefits and, in this context, effective communication was an indispensable component of the delivery of medical services. To hold otherwise was, for the Supreme Court, a “*thin and impoverished view... of equality*” [para 73]

New Zealand has a very limited Bill of Rights centred on the protection of basic civil liberties. However, in the case of *Shortland v Northland Health Ltd* [1998] 1 NZLR 433 this did not prevent the Court of Appeal, through a generous interpretation of the right to life as protected by Article 8 of the Bill of Rights, and drawing on the equivalent international provision - Article 6 of the International Covenant on Civil and Political Rights (ICCPR) - from assessing a clinical decision to withdraw dialysis treatment according to human rights principles. In so doing the Court recognized that s 151 of the

³³ See for example decisions such as *Corbiere v Canada* [1999] 2 SCR 203 and *M v H* [1999] 2 SCR 203. This approach has been criticised by the leading Canadian constitutional commentator Peter Hogg as ‘vague, confusing and burdensome to claimants’ Hogg *Constitutional Law of Canada* (Student Edition Carswell 2002) p 1059

Crimes Act 1961 placed a legal duty on the local health authority to supply the patient with ‘the necessities of life’ and that a failure to perform that duty ‘without lawful excuse’ could lead to criminal responsibility. The Court noted that this positive duty was related to the right to life as guaranteed by Article 6(1) of the ICCPR and the understanding of that provision as elaborated by the United Nations Human Rights Committee in its General Comment 6.

The Court held that extent of the duty to provide the necessities of life must be assessed in the context of the intensive appraisal of the patient’s condition by the clinical team which had knowledge of his condition and his ability to benefit from dialysis. In so doing it recognized that judges were concerned with the lawfulness of the decision to discontinue dialysis and not with the likelihood of the effectiveness of the treatment³⁴. Hence, the Court found that, in light of the careful assessment of the patient by the clinical team, who had come to a *bona fide* decision that the cessation of treatment was in his best interests, Northland Health could not be said to be in breach of its duty to provide the necessities of life and that therefore the decision to withdraw dialysis was not objectionable and would not deprive the patient of his right to life.

The Court of Appeal’s approach clearly mirrors that of the South African Constitutional Court in *Soobramoney* (see above) with judges recognizing that in right to health issues there are clear boundaries which they should not cross. Their main task is to assess whether those responsible for providing treatment had done all they could reasonably could do in the circumstances either in terms of making clinical decisions or how to manage limited resources.

The UK courts, in the absence of the right to health or any esr guarantees incorporated into our domestic law, have again needed to adopt a creative approach using the limited set of fundamental civil guarantees contained in the European Convention on Human Rights that have been incorporated through the Human Rights Act 1998, in particular those safeguarding against cruel and inhuman treatment and respecting family life.

³⁴ The Court applied the English Court of Appeal decision *R v Cambridge Health Authority; ex parte B* [1995] 1 WLR 898 at 905

However, it is important to recognise that in the UK, as in other jurisdictions where health rights are not entrenched, this is still very much an emerging area of law and that the record is mixed at best, as illustrated by a number of recent cases.

In *Watts, R (on the application of) v Bedford Primary Care Trust & Ors* [2003] EWHC 2228 the High Court considered the extent of the state's positive obligations to provide healthcare regarding a claim for reimbursement of costs following treatment abroad. The applicant relied on both Articles 3 and 8 of the ECHR. The Court recognized the wide reach of both provisions and that "*the Strasbourg jurisprudence demonstrates that Articles 3 and 8 do not only impose on the State merely negative obligations not to act in such a way as to interfere with the rights protected by those Articles. They also in certain circumstances impose positive obligations to take measures designed to ensure that those rights are effectively protected.*" [para 45]. However, Munby J went on to hold that in the light of the Court of Appeal decision *R v North West Lancashire Health Authority ex p A* [2000] 1 WLR 977, Article 8 imposes no positive obligations to provide medical treatment and that the pain and suffering endured by the applicant in not receiving treatment was not sufficiently serious to engage Article 3. Although the applicant was not able to succeed using human rights law he was able to on the basis of European Community law. Nevertheless, it appears unlikely until *R v North West Lancashire Health Authority ex p A* is overruled that claims for meeting medical treatment costs based solely on human rights arguments will succeed.

However, this does not mean that positive healthcare issues cannot engage the Human Rights Act. In *Goldsmith, R (on the application of) v London Borough of Wandsworth* [2004] EWCA Civ 1170 the Court of Appeal addressed the failure of a local authority to sufficiently consider a patient's right to private life under Article 8 of the ECHR when deciding to transfer her to a nursing home. The Court concluded inter alia that the decision-making process had not acted in the best interests of patient in securing her health, together with a complete failure to take into account her Article 8 rights, thereby recognizing that a patient's right to respect for her private life does not cease upon her entering a healthcare institution.

A number of recent decisions could have a significant impact – both positive and negative – on the health of asylum seekers, a particularly vulnerable segment of the British population. On the positive side the courts have recognised that asylum seekers should not be thrown into destitution by denying them access to welfare benefits. This was affirmed by the Court of Appeal in *Secretary of State for the Home Department v Limbuela & Ors*³⁵ [2004] EWCA Civ 540 when it held that the state has a duty under Article 3 of the ECHR to prevent homeless asylum-seekers from suffering destitution even where they had failed to make an asylum claim as soon as reasonably practicable under s 55(1) of the Nationality, Immigration and Asylum Act. Applying *R (Q) v Secretary of State for the Home Department* [2004] QB 36 the Court held it was not necessary for the claimant to show the actual onset of severe illness or suffering for a claim to be established. If the evidence established clearly that charitable support in practice was not available, and that he had no other means of fending for himself the presumption would be that severe suffering would imminently follow. The majority of the Court recognised that the correct approach was one of prevention rather than ‘wait and see’ which could result in the victim having to endure unnecessary suffering before upholding a claim. An appeal was heard by the House of Lords in October 2004 and at the time of writing a judgment is yet to be handed down. The consequences of the decision being overturned for the health of many asylum seekers would be dire.

Limbuela, involving as it did the positive obligation of the state to provide basic sustenance for the individual, irrespective of status, in order to prevent them suffering cruel and inhuman treatment did not require recourse to arguments based on the right to health or any other relevant economic and social rights guarantees, such as right to housing. However, two other recent decisions illustrate the dangers for claimants of not being able to argue esrs which have either been incorporated into domestic law³⁶ or constitutionally entrenched. Both cases concerned the right of access of failed asylum seekers to medical treatment in the UK. In *Dbeis and Ors v Secretary of State for the*

³⁵ Two other cases were joined in the hearing : *R v Secretary of State for the Home Department ex p Tesema* and *R v Secretary of State for the Home Department ex p Adam (FC)*.

³⁶ Although the UK has ratified the ICESCR, together with all of the other major UN human rights treaties, it has yet to incorporate any of them into domestic law

Home Department [2005] EWCA Civ 584 the Court of Appeal ruled that it was reasonable to return a failed asylum seeker and her son suffering from cerebral palsy to her country of origin where there were adequate medical and education facilities. The applicant had to argue her claim under Article 8 of the ECHR, but in the absence of any express entitlements to healthcare the Court ruled that the case did not satisfy the exceptional test laid down in a previous case³⁷ and that therefore both her and her son could be deported back to the Lebanon. The case affirms a high threshold for those seeking to argue that health or other social needs should act as a bar to deportation.

An even more disturbing decision was made by the House of Lords in *N v Secretary of State for the Home Department* [2005] UKHL31 when it found that that the UK had not breached Article 3 of the ECHR by deporting a failed asylum seeker with terminal HIV/AIDS back to her country of origin despite the fact that Uganda's medical facilities were clearly significantly less advanced than the UK. The Court distinguished *D v UK* (1997) 24 EHRR 423, the European Court of Human Rights decision relied on by the appellant, on the grounds that the situation in the receiving state were not as extreme as that faced by a terminally ill patient in that case where there was no prospect of any medical care or family support. For their Lordships a claim would only succeed where "*the applicant's medical condition has reached such a critical state, that there are compelling humanitarian grounds for not removing him or her to a place which lacks the medical and social services which he or she would need to prevent acute suffering.*" [para 94]. Therefore Article 3 did not require contracting states to undertake the obligation of providing aliens with indefinite medical treatment lacking in their home countries. To hold otherwise they maintained would be to open the floodgates to a myriad of claims placing an unreasonable burden on the state. Whilst expressing sympathy for the appellant's plight and reminding the Home Secretary that he was not bound to deport her but could exercise his discretion, their Lordships concluded that she should not be allowed "*to remain in the host state to enjoy decades of healthy life at the expense of [the] state*" [para 92]. Yet their Lordships admitted themselves that without the necessary

³⁷ See *R (Razgar) v Secretary of State for the Home Department* [2004] 3 WLR 58

medication she had been receiving in the UK the appellant's life expectancy could be two years at best and the chances of receiving such treatment in Uganda was problematic.

One is left with the conclusion that if N could not qualify for Article 3 protection then who will in the future? It is clear that the House of Lords, as they themselves recognised, faced difficult moral choices in the case. Yet, whilst acknowledging that a line must be drawn somewhere to prevent the state (even one as wealthy as the UK) becoming overburdened, it is submitted that the scope of the protection offered to desperately ill people in the wake of *N v Secretary of State for the Home Department* is too narrow. It is also worth considering how the decision might have differed if N could have argued that she had a right to receive treatment as part of an explicit right to health under domestic law and that, given her serious condition, it was unreasonable to deport her. This is not a *Soobramoney* case where the patient, whatever the nature of the treatment she received, would only have a short period to live.

A recent decision from the Australian Federal Court of Appeal, albeit one without the resource considerations of the House of Lords case, offers a more positive example of how the situation in other countries can and should be taken into account as part of the state's decision making process. The Court in *De Bruyn v Minister of Justice and Customs* [2004] FCAFC 334 was required to consider whether it would be unjust, oppressive or incompatible with humanitarian considerations to extradite a detainee to South Africa due to the risk of his contracting HIV/AIDS in prison. The Court, in holding that the prison conditions in the requesting country must be taken into consideration, ruled that the Minister had failed to address the question whether, in the circumstances of the case, it would be oppressive or incompatible with humanitarian considerations to surrender the subject to a country when there was a risk of contracting HIV/AIDS considerably greater than if he was not surrendered.

Conclusions

This limited survey of right to health jurisprudence has demonstrated that absence of express constitutional protection is not a bar to consideration of health issues by other courts. However, it will often require a creative approach and generous interpretation of existing guarantees by both lawyers and judges in order to give true meaning to the principle of indivisibility and interdependence of rights. Courts, whether assessing constitutionally entrenched rights, incorporated guarantees or conducting a more limited form of review, will need to be mindful of how far they can go in determining claims with often significant resource and policy implications as well as difficult moral choices. They will naturally be reluctant to supplant clinical decisions by health professionals but may be prepared to intervene if the state is considered to have acted unreasonably in denying services or medication to patients. Even where positive judgments are handed down the challenge of enforcement frequently remains, requiring both an active judiciary and committed health rights activists. Above all, reference to comparative and international law from a range of jurisdictions and fora should contribute to a greater understanding and appreciation of the right to health and other economic and social rights and, ultimately, to improved protection.