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SOME COMMENTS ON THE HIGHEST ATTAINABLE STANDARD OF HEALTH

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Abstract: *The last decades present a significant development of the economic, social and cultural rights and specifically, the right to health. Until 2000, the right to health has not been interpreted officially. By providing international standards, General Comment No.14 on the right to the Highest Attainable Standard of Health has led to wider agreement that the right to health includes the social determinants of health such as access to various conditions, services, goods or facilities that are crucial for its implementation. The Reports of the Special Rapporteur on the right to health within the UN human rights system have contributed to the process of gaining the greater clarity about the right to health. It is obvious that achieving the highest attainable level of health depends on the principle of progressive implementation and the availability of the necessary health resources. The possibility individual complaints to be considered by the Committee on Economic Social and Cultural Rights was introduced with the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, entered into force in 2013.*

Keywords: Highest attainable standard of health, states' obligation, right to health care.

1. Introduction

The last decades present a significant development of the economic, social and cultural rights and specifically, the right to health. Until 2000, the right to health has not been interpreted officially. Then, after several years of discussion, the Committee on Economic, Social and Cultural Rights, that does the UN monitoring of the International Covenant on Economic, Social and Cultural Rights (ICESCR) application, adopted an expansive interpretation of the right to health. By providing international standards, General Comment (GC) No.14 on the right to the Highest Attainable Standard of Health has led to wider agreement on the major elements of the right to health.

2. Broad notion of right to health – freedoms and derivative rights

Health and health care became the explicit although controversial human right after the World War II. The WHO Constitution adopted in 1946 provides in its preamble as follows: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." The foundations of the international legal order regarding the right to health were laid two years later in paragraph 1 of Article 25 of the Universal Declaration of Human Rights. In the next decades various international and regional human rights treaties which include the right to health have been adopted [1].

Article 12 of the ICESCR represents a

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cornerstone of the protection of the right to health under the international law. Thus, the Covenant's provisions are legally binding for all 170 ratifying states (last ratifying is Myanmar in 2017). According to it and other international and regional human rights instruments the right to health includes both freedoms and derivative rights. Freedoms include non-discrimination, free decision-making that affects the health and physical integrity of the person, free and informed consent, freedom from scientific experimentation, as well as the freedom "from torture and cruel, inhuman or degrading treatment or punishment" as stated in Art.7 of the ICCPR.

Derivative rights include the right to primary health care and for access to essential medicines. The right to health covers the so-called 'fundamental determinants of health' such as access to clean water and adequate sanitation, sufficient food supplies, food and housing conditions, as well as access to health information and facilities. This is underlined in the Report of the Special Rapporteur on the rights of persons with disabilities dedicated to health theme (A/73/161), distributed on 16 July 2018.

The right to health is a wider concept which covers some other specific rights such as right to maternal and reproductive health, to children's health; to occupational health and healthy environment; prevention, treatment and control of diseases, including access to first-aid medicines; access to clean water etc.

3. Right to health's social determinants

It should be pointed that according to the 2007 Report of the Special Rapporteur Paul Hunt on the highest attainable standard of physical and mental health (A/62/214) clean water supply and proper sanitary conditions are two interlinked key determinants, important for the realization of the highest possible standard of health. Unsufficient access to clean water and sanitary conditions threatens life, undermines health, deprives persons of appropriate opportunities, degrades human dignity.

Considering the abovementioned, the right to health could be described as an important and comprehensive human right. Recently, the Committee on Economic, Social and Cultural Rights, governmental and non-governmental organizations and scientists have analyzed the right to health and health care in order to facilitate its understanding and practical application in strategies, programs and health projects (for example, General Comment No. 14).

The Special Rapporteur also tries to improve these principles of analysis while preparing his countries and other reports. He urges that governments to apply them, as they will help them to gain a better notion of the right to health and enable them to make medical and other measures more effective. Thus, the principles of analysis will provide a common platform for discussing a variety of health issues through the prism of the human rights.

The very appointment of the Special Rapporteur for the right to health within the UN human rights system in 2002 has also contributed to the process of gaining the greater clarity about health as human right. The first Special Rapporteur Paul Hunt, who served between 2002 and 2008, played an important role in clarifying the legal content of the right to health. His reports cover and provide greater depth to a number of important topics, including health indicators (2003), sexual and reproductive rights (2004), mental disabilities (2005), reduction of maternal mortality (2006), the prioritization of health interventions and the role of water and sanitation (2007), and the role of health systems (2008) [2]. His two successive heirs to this post, namely Anand Grover and Dainius Pūras continue the same development.

It is pointed out by Audrey R. Chapman, one of the most important innovations in

General Comment No. 14 is the interpretation of the right to health as a human right incorporating the important determinants of health such as access to variety of services, goods or facilities that are crucial for its implementation [2]. These determinants of health include the conditions in all life stages, connected with the health system. To great extent they are determined by the distribution of financial and political resources of the world at the different levels. It is the social determinants of health that underlie most health hazards, i.e. discriminatory and eliminating differences in health outcomes observed in and between countries. That is why in 2008 the Commission on Social Determinants of Health appeals for "closing the health gap in a generation" [3]. The Commission admits that there are huge differences in health closely linked with the unequal social development even within the sole country. Globally, in one part of the world the average life duration for men can be 54 years, while on the other continent, it is 82 [3]. Improved and fair health conditions are an objective that should be perceived by all international actors.

General Comment No.14 clarifies some aspects of the right to health but does not define it in a clear and proper way. Meanwhile, it does state that the right to health **does not mean the right to be healthy** (par.8). This has been confirmed in paragraph 32 of the 2005 Special Rapporteur's Report on the highest attainable level of physical and mental health (E/CN.4/2005/5). It is more the right to be admitted to institutions, goods, services and conditions that contribute to the highest attainable level of physical and mental health.

4. Right to health and the right to health care

Sometimes, the right to the highest attainable level of health is narrowly understood as the right to health care. Notwithstanding, this attitude does not comply with international human rights law, which encloses both medical science and public health. Medicine focuses primarily on the health status of individuals and public health is concerned with the prevention of deseases and the conditions considered healthy for the general population. As it is summarized by Audrey R. Chapman, the two paradigms of medicine and public health give rise to conceptions of health and related rights that in the case of the former tends to emphasize access to health care and for the latter - the social determinants of health, and the preventive health services [2].

Although the right to health is interpreted as a right to health care, obviously, its meaning in Article 12 ICESCR and GC No.14 is **broader**. Not only the International Covenant on Economic, Social and Cultural Rights, but also the Convention on the Rights of the Child (CRC) explicitly state that the right to health includes much more than just access to medical care. In particular, article 24 of the CRC provides that the right to health means access to sufficient food supply, safe drinking water, sanitary conditions, taking into account the need to protect the environment, etc., and also to medical care. Equalizing the right to health with the right to health care represents a wrong understanding of international human rights law.

Nevertheless both instruments, namely ICESCR and GC No14, offer narrower interpretation of health, compared to WHO. The preamble to the Constitution of the WHO conceptualizes health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". If it includes all individuals, this is simply an impossible aim. Some critics argue that the WHO approach mistakenly implies that good health is an end rather than a limited means to a fruitful and meaningful life [4].

Despite everything said so far, some authors probably will have their doubt about the comprehensive perceptions of the right to health. Some criticism might appear

in regards that all individuals are granted to 'the highest attainable standard of physical and mental health'. In the light of these possible concerns, the researcher Simon Caney proposes a different perspective to the right to health. He suggests the following definition of the right to health: "all persons have a human right that other people do not act so as to create serious threats to their health" [5]. This interesting approach shows two major differences from the ICESCR and CRC approach: first and foremost, there is no commitment from the states side to ensure the health and well-being of the whole population. The second difference reveals that a positive right does not require maximalist approach to health and well-being of the individuals. It correlates with the obligation not to violate the health rights of others.

The Human Rights Committee, in its General Comment No.6 (1982), stressed that States parties needed to take constructive measures to increase life expectancy and to eliminate the major health risks in order to promote the right to life [6].

5. States'obligation

States have a duty to respect, protect and exercise the right to health. Accordingly, States should refrain from direct or indirect encroachment on human health; take steps to prevent such third-party encroachment; and to take positive measures to enable physical persons and society to exercise that right and to assist them in doing so. In addition, States must ensure that medical supplies, services and facilities are available in sufficient quantities (availability); were financially and physically accessible, including geographically, including accessible information and communication without discrimination (accessibility); complied with medical ethics, were culturally acceptable and took into account gender and life-cycle requirements (acceptability); were scientifically and medically acceptable and had good quality (quality). The right to health also requires public participation in decision-making on all health-related issues (par. 10 of the Special Rapporteur's Report on the Rights of Persons with Disabilities A/73/161).

The exercise of the right to health includes, *inter alia*, access to institutions, goods and health facilities that are scientifically and medically acceptable and of high quality, and "the right to be free from any interference, such as the right to be free from torture and not to be subjected without free consent to medical or scientific experiments". Furthermore, Article 7 of the International Covenant on Civil and Political Rights declares that "no person should be subjected to medical or scientific experiments without his or her free consent". States have responsibility to respect, protect and exercise the right to health, including through abstinence from compulsory treatment, except in emergency cases involving treatment and prevention of infectious diseases (paragraph 32 of the Special Rapporteur's Report on individual's right to the highest attainable level of physical and mental health A/65/255).

The regional treaties and domestic laws oblige States to take appropriate measures to ensure compliance, protection and exercise of the right to health and to combat corruption when it affects their obligations to the right to health. They should be considered in order to combat corruption, along with other legal instruments such as the United Nations Convention Against Corruption (Par. 23 of the Special Rapporteur's Report (A/72/137).

The international right to health imposes certain immediate obligations. For example, it covers the freedom from compulsory medical treatment. The use of this freedom does not depend on the consistent implementation or on the availability of resources. Similarly, the non-discrimination requirement must be implemented immediately (par. 34 of the Special Rapporteur's Report).

6. 'To the maximum of available resources'

The right to the highest possible level of health depends on the principle of progressive implementation and the availability of the necessary health resources. Each state party that has signed and ratified the ICESCR, has "to take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of available resources"[7]. Thus, the implementation of rights listed in the Covenant was made conditional on the availability of resources. This approach is very different from the framework of the International Covenant on Civil and Political Rights, which has no similar provisions. The biggest problem is how to assess what the phrases "to take steps" and "to maximum of its available resources" mean.

There may be different approaches to the interpretation of the concept of 'available resources' because the term has not been accurately defined in the regulatory framework of the law on health or in General Comments No.3. Available resources can be understood as the total amount of the State's GDP, the amount or percentage allocated by the state to the health system or allocated for achieving a specific health target. States need to allocate sufficient resources to ensure the implementation of economic, social and cultural rights. Therefore, "available resources" have to be understood as such maximal amount of resources that can be assigned to an important health target without undermining other socially significant activities. It should be noted that providing the necessary resources to realize other rights can lead to greater accessibility, availability and quality of health goods, services and facilities.

The Optional protocol to the ICESCR from 2008, which came into force in 2013, requires that the Committee also consider "the appropriateness of the measures taken by the State party" (Article 8, par.4) determining such a feasibility, for example - whether the measures taken are intentional, specific and targeted; whether resources were allocated in accordance with international human rights standards; whether the living conditions of vulnerable groups were taken into consideration, etc.[8] But probably the main achievement of the Optional protocol to the ICESCR is the provided possibility individual complaints to be considered by the Committee on Economic Social and Cultural Rights. The Optional Protocol to ICESCR entered into force in 2013 [9].

The editor-in-chief of *The Lancet* Richard Horton points out that the states should pay greater attention to health issues. In his article he underlines that "Health policies matter because they underlie the fundamental commitments of governments to the dignity of their people" [10].

It should be noted that approximately one-third of the world's population, most of whom are migrants or live in low- and middle-income countries, still lack access to essential medicines or medical care [11]. It is estimated that improving access to basic medical services and medicines could save some ten million lives every year.

The right to health as a part of the concept for human dignity sometimes might be contradictory to the state's obligation to provide adequate health care. This was the question in case *Hristozov v. Bulgaria* (Applications No. 47039/11 and 358/12), held in front of the European Court on Human Right. All applicants were terminally ill patients with cancer. Four of them died during the court proceedings. They have unsuccessfully tried for a long period of time the available conventional cancer treatments such as chemotherapy, radiotherapy and hormone therapy etc. The applicants then sought defence in regard to the authorities' refusal to allow them to use an experimental medicinal product that had been developed by a Canadian company and was permitted in some countries. This

anti-cancer experimental product was offered only in a private clinic in Sofia. The applicants sought authorisation to use the product but were denied on the ground that the product was not allowed for use in Bulgaria. The applicants alleged that they did not have an effective remedy in that respect. The Court held that there had been no violation of the European Convention on Human Rights. With respect to Article 2 of the Convention, it stated that while Article 2 imposes a duty on the state to establish a legal framework to protect people's lives, it could not include a duty to allow access to an unauthorised and experimental medicine. Clearly, this could not be considered as a part of state's obligation to protect its citizens' health.

Today COVID-19 poses a challenge to governments and the international community - how to protect public health in the most appropriate way and how to support the vulnerable groups at risk [12]. In 2005 the International Health Regulations (IHR) under the auspices of the WHO were signed in order to reduce the spread of infectious diseases "that presents or could present significant harm to humans", or to any "public health emergency of international concern (PHEIC)" (Art.1). [13] The IHR represent a legally binding instrument of international law for global health security. They refer to any extraordinary event caused by the international spread of disease that may threaten another states' public health (Art.12) and that envisages a coordinated international response (Art.14). The Regulations represent binding act under the international law and were signed not only by the WHO Member states. The IHR entered into force on 15 June 2007. Since then, the WHO Director-General has several times declared "public health emergencies of international concern" (in regard to H1N1 influenza pandemic, Zika, Ebola, etc.)

It is obvious that the realization of the right to health is not possible without cooperation and assistance within the international community. General Comment No14 states clearly: "Given that some diseases are easily transmissible beyond the frontiers of a State, the international community has a collective responsibility to address this problem". The document continues that the economically developed States have "a special responsibility and interest to assist the poorer developing states in this regard" (par.40).

7. Conclusion

The article reveals the evolution to a broader interpretation of the right to health - as an inclusive right incorporating the social determinants of health such as access to as access to various conditions, services, goods or facilities that are crucial for its implementation. The adoption of General Comment No.14 as well as the Reports of the Special Rapporteur on the right to health also contributed to the process of gaining the greater clarity. It is obvious that the right to the highest attainable level of health strongly depends on the availability of the necessary financial and medical resources. However, even the current situation with COVID-19 emphasizes that the realization of the right to health is not possible without international cooperation and assistance.

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