

The International Human Right to Health: What does it mean for Municipal Law in Ghana and Pakistan

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Abstract

Health has universally been recognised as an important dimension of human flourishing. This has been recognised at the global and regional level by protection of the right to health/health care in international human rights instruments. The content of this right has been explored and explicated within the context of the major international human rights instrument enshrining the right to health. Apart from international human rights instruments, municipal legal systems also recognise the right to health explicitly or tacitly. Ghana and Pakistan have been selected to explore the extent to which the international right to health has been domesticated in both countries. The article also attempts to understand how right-based approach is better than the policy based approach towards healthcare and how positively/effectively it can influence health reforms in the national legal system.

Key Words: health, human right, economic social and cultural right, international human rights, municipal law.

1. Introduction

Health remains an important condition for human flourishing in all civilizations and societies. It is the fulcrum of all other cherished goods of human existence because without good health the quality of human material existence will greatly be diminished. Aristotle is once quoted to have stated that: 'if we believe men have any personal rights at all as human beings, they have an absolute right to such measure of good health as society and only society alone is able to give them' (Papadimos, 2007). However, the legal frame work to safeguard freedoms and liberties do not appear to explicitly acknowledge the preeminence of health. Indeed, the over emphasis of civil and political rights from the inception of formal legal recognition of human rights underscores our preliminary observation. In this paper, we seek to explore first, the basis or existence of right to health under international human rights law; second, the content of the right to health and finally the extent to which

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right to health has been given prominence in selected municipal legal systems from the perspectives of the violations approach.

2. Basis of Right to Health under International Human Rights Law

Before attempting to locate the right to health in international human rights law, it is apposite to have some clarity about relevant terms often associated with its discourse. “Health” and “Health care” are not amenable to straight forward definition because of their inherent vagueness. According to the World Health Organization (WHO) “health” may be defined as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (<https://apps.who.int/aboutwho/en/definition.html>). We consider this definition to be all encompassing as it brings under the canopy of health anything that contributes to the total wellbeing of a person. While the holistic approach of the WHO is admired, on a closer observation it appears to be too ambitious as it seeks to almost reduce everything that contributes to wellbeing of a person into a health issue. This will practically blur any boundary that one may seek to delineate between right to health properly so-called and health rights generally. The other difficulty with the WHO’s definition of health is that it complicates rigorous assessment of legal framework for health care as the definition is excessively elastic and could potentially translate every law and policy into health care law. Indeed every law in every country can directly or indirectly affect health in the sense of impinging on the total wellbeing of individuals. Due to the conceptual difficulties inherent in the WHO’s definition other approaches to understanding health may be explored. Montgomery has identified two contrasting approaches to health, namely the social model and the engineering or mechanical model of health. According to the social model our health is affected by diet, environment, how our society is organized, life style and genetic hereditary. This model is practically concerned with the remote causes of ill-health. Adopting social model as a working conception of health will infinitely broaden up right to health that include almost everything such as legal controls on quality of food, environmental protection, provision of public housing and welfare benefit. We consider this approach to be unhelpful as it will make every issue a right to health issue. This drawback in the social model is very much similar to the weakness in the WHO’s definition discussed above. The engineering or mechanical model on the other hand uses the analogy of machine and conceptualizes health as the adequate functioning of the human body, prevention of its breakdown and repairing it where necessary (<https://apps.who.int/aboutwho/en/definition.html>). It is our submission that engineering model is preferable as it enables the right to health to be largely confined to the control of disease and provision of health care services. Notwithstanding, the foregoing taxonomical analysis, the true import of ‘health’ in human rights discourse is contingent upon how the right to health

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has been conceptualised in the various international human rights instruments.

The history of human rights is very old; the idea that every individual has human rights has its origins in most of the world's major religions. In this regard two basic precepts are recognised: (1) worth of the human beings, and (2) human beings, in turn, are accountable to God for their actions toward other human beings whoever they may be. We generally attribute the origins of modern notions of human rights to the Eighteenth Century Enlightenment and the English Revolution of the Seventeenth Century. The legacy of the Eighteenth Century Enlightenment and the English, American and French Revolutions was recognition of civil and political human rights for all human beings primarily in relation to their governments. The Eighteenth Century Enlightenment did recognize one economic right, the right to property, which served as the basis of the emerging economic system of capitalism in the Industrial Revolution. Economic, Social and Cultural rights, emerged primarily from the economic dislocations of the Industrial Revolution. It is important to note that the human right to health has different origins; notions of a positive right to health had its origins in the Sanitary Revolution of the Nineteenth Century when public health reformers, also troubled by the economic dislocations of the Industrial Revolution and empowered with scientific advances, pressed for state-sponsored public health reforms. The horrors, suffering and human tragedy in the wake of World War II leading to the establishment of the United Nations (UN) are the primary triggers in the evolution of the modern corpus of international human rights law and the current international human rights system. The UN embraced the recognition and protection of human rights as a core strategy for world peace. Since the adoption of the Universal Declaration of Human Rights in 1948 by the UN, a substantial body of international human rights law has developed recognizing basic rights and their promotion and protection¹. In brief, there are two major sources of international human rights law that are relevant to the right to health: (1) UN Human Rights System (2) regional human rights mechanism such as the African Charter on Human and Peoples Rights.

2.1. International Treaties

The Universal Declaration of Human Rights, 1948 (UDHR) is not a treaty in a sense that it does not create binding legal obligations, but a statement of policy and a call to action. It is worth noting that the UDHR has attained the status of customary international law in the area of human rights. Many states that have gained independence after 1947 and/or adopted written constitution have incorporated most of the principles enshrined in the UDHR including Pakistan.² The UDHR affirmatively states a human right to health: 'Everyone

has the right to a standard of living adequate for the health and well-being of himself and of his family, including . . . medical care . . . and the right to security in the event of . . . sickness, disability ...' (UDHR 1948). In the 1960s, the UN sponsored the development of two international covenants that articulate the human rights recognized in the UN Universal Declaration of Human Rights. These two covenants are the International Covenant on Civil and Political Rights (ICCPR), 1966³ and the International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966.⁴ The International Covenant on Economic, Social and Cultural Rights (ICESCR)—the so-called Economic Covenant—is the most important in terms of the right to health. In relation to the right to health, the ICESCR manifests the human right to health in its Article 12, stating that:

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.⁵

The UN Committee on Economic, Social and Cultural Rights

(ECOSOC) has responsibility for the promotion, implementation and enforcement of this covenant. A human right to health is also recognized in numerous other international human rights instruments put prohibitions on states' conduct considered detrimental to health. Such treaties include the International Convention on the Elimination of All Forms of Racial Discrimination (CERD) 1965,⁶ the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) 1979,⁷ and the Convention on the Rights of the Child (CRC) 1989.⁸

Apart from the UN system, the right to health is also recognised in regional human rights instruments. The African Charter on Human and People's Rights imposes an obligation on state parties to provide health care to their citizens.⁹ Article 16(1) stipulates: '[e]very individual shall have the right to enjoy the best attainable state of physical and mental health.' Article 16 (2) enjoins States Parties 'to take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick' (The African Charter). Unlike other clauses, containing claw back clauses, in the

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African charter, the obligation of state parties to provide health care to their nationals is without limitation. The African Commission on Human and People Rights has held that 'the failure of the government to provide basic services necessary for a minimum standard of health, such safe drinking water and electricity and the shortage of medicine as alleged in communication 100/93 constitutes a violation of Article 16 of the Charter' (Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 15 on the Right to Water, , 2003).

3. Content of the Right to Health

The right to health has until recently remained vague (E., 2001). In August, 2000 the Committee on Economic, Social and Cultural Rights adopted 'General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)' (Contained in Document E/C., 2000). The right to health was explicated not to be necessarily the right to be healthy. On the other hand the normative content of the right to health was among others noted as:

8. The right to health is not to be understood as a right to be *healthy*. The right to health contains both freedoms and entitlements. 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. 9. The notion of "the highest attainable standard of health" in article 12.1 takes into account both the individual's biological and socio-economic preconditions and a State's available resources. There are a number of aspects which cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health. Thus, 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. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health (General Comment No. 14, n.16 above).

If one looks at the complex nature of the right to health, a number of distinct dimensions have to be borne in mind. On the one hand, the right embodies the freedom to make decisions about one's own health data, such as medical records; on the other hand, the right to health also embraces an entitlement to

a system of health care protection. Thus the availability of health services, facilities and products of good quality represents a comprehensive dimension, while the actual individual rights guarantee represents another equally important dimension. As can be discerned from the above quotation, General Comment No. 14 enumerates the nuanced dimensions of the right to health. The freedom dimension of the right to health includes questions of sexual and reproductive health, the right to be free from interference with one's body, such as non-consensual medical treatment. The entitlement dimension addresses such issues as the right to emergency medical services, and to the underlying determinants of health, such as adequate sanitation, safe and clean water, adequate food and shelter, safe and healthy working conditions, and a healthy environment. If these underlying determinants of health are not met, the right itself cannot properly be protected.

Undoubtedly, some of the aspects of the right to health create state obligations that are quite heavily resources dependent. Nevertheless, in order for the human race in every country to survive certain minimum core or threshold of obligations under the right to health must be met by state parties. Indeed, aspects of the right to health and 'the entitlement components of that right, a relatively small but essential number of core obligations can be made out which all states, whether rich or poor, should be able to meet in all circumstances, because they are not resource-dependent, or only to a very limited degree, comparable to any civil or political rights situation' (E, 2009) (http://www.swisshumanrightsbook.com/SHRB/shrb_03_files/01_453_Riedel.pdf). Accordingly, states without exception are obliged:

- (a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups, (b) to ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone, (c) to ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water, (d) to provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs, (e) to ensure equitable distribution of all health facilities, goods and services, and (f) to adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population ... (<http://www.unhcr.org/cgi-bin/texis/vtx/refworld/rwmain?docid=4538838d0&page=search>).

All human rights obligations including the right to health have three dimensions (This has been stressed in General Comment No. 14). These are

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the obligations to *protect, respect and fulfil*. The obligation to respect requires states to refrain from interfering directly or indirectly with the enjoyment of the right to health (General Comment No. 14, n.16 above). Thus, the state must avoid any action or activity which would hamper the equal enjoyment of access to preventive, curative or palliative health services, such as access to contraceptives, health related information or traditional preventive care, healing practices and medicines. The obligations to protect include, inter alia, the adoption of legislation, or the taking of other measures ensuring equal access to health care and health-related services provided by private health facilities. The state has to further ensure that medical practitioners, and other health professionals, meet appropriate standards of education, skills, and ethical codes of conduct. States also obligated to protect their population from harmful traditional practices, ensure access to pre and post-natal care and family planning, and to combat female genital mutilation where this still represents a widespread social practice (General Comment No. 14, n.16 above). On the other hand, the obligation to fulfil enjoins states, inter alia, to give sufficient recognition to the right to health in the national political and legal systems, and to adopt a national health policy containing detailed plans for realizing the right to health (General Comment No. 14, n.16 above). States Parties must also provide adequate health care, including immunization programmes against the major infectious diseases (General Comment No. 14, n.16 above).

The Right to Health in Municipal Legal Systems

After 2000 when General Comment 14 was adopted, it signified a sort of international consensus on the status and normative content of the right to health under international human rights law. However, the existence of international human right norm does not automatically translate into national or municipal legal systems. It ultimately depends upon whether a country follows a monist or dualist approach for treaty adoption. We turn now to explore the extent to which Ghana and Pakistan have incorporated the right to health in their domestic legal systems.

A. GHANA

The supreme law of Ghana expressly provides for the protection and promotion of human rights of all peoples. Article 12 (2) unambiguously stipulate that 'Every person in Ghana, whatever his race, place of origin, political opinion, colour, religion, creed or gender shall be entitled to the fundamental human rights and freedoms of the individual contained in this Chapter but subject to respect for the rights and freedoms of others and for the public interest' (1992 Constitution of the Republic of Ghana). Article 34(2)

of the 1992 constitution of Ghana recognizes health as a human right and mandates a sitting President to ensure the realization of basic human rights; the right to good health care of every citizen¹⁰. However, article 34 forms part of Chapter Six (Directive Principles of State Policy) of the constitution. The status of the right to health care under Ghana's constitution appears to be somewhat doubtful when juxtaposed with other rights. For example, the right to education which follows the right to health in the enumeration of rights contained in article 34(2), noted above, is repeated in article 25 elaborately. Since article 25 is located in chapter five of the constitution (Fundamental Human Rights and Freedoms) it can be considered as having more prominence than the right to health. This is particularly worrying when account is taken of the fact that until recently the directive principles of state policy under which right to health care is subsumed, was largely held to be non-justiciable (*New Patriotic Party v Attorney General*, 1993). 'An issue is justiciable if it is capable of being settled by a court' (*Ghana Lotto Operations v National Lotto Authority*, 2007). In the *Lotto case*, the Supreme Court has emphatically declared that there is a rebuttable presumption for justiciability of rights and other provisions contained in the Directive Principles (*Ghana Lotto Operations v National Lotto Authority*, 2007: 1106). Thus, it can be contended that 'the right to health care' mentioned in article 34 (2) forms part of the enforceable rights under the constitution. A survey of law reports in Ghana we undertook did not reveal any reported case concerning direct or implicit enforcement of the right to health care. The paucity of case law could be explicated by the obscurity which was accorded the right to health in the Constitution. Unlike other rights which have prominently been enshrined in a dedicated chapter on fundamental human rights and freedoms in the constitution, the right to health was briefly mentioned in a chapter on directive principles of state policy.

Admittedly, if there had been adequate appreciation of the right to health among the citizenry and the legal community in Ghana, Ghana's obligation under international law could have been relied upon in litigation. Ghana is a party to the ICESCR, the African Charter and many other international instruments directly or indirectly protecting the right to health. In terms of article 40 of the Constitution, Ghana is obligated to fulfil her commitments to international organisation. However, being a dualist country, article 75 requires domestication of international instrument before their contents could have efficacy within the municipal legal system. It follows that if a suit seeking to enforce the right to health had been pegged on Ghana's general obligation under international law, it might have been an uphill task having regard to unambiguous provisions of article 75. The fact that the constitution in a dualist country should not, in principle, be a challenge to the protection of rights since the framers of the constitution purposefully made the provisions on rights

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expandable. The constitution thus makes room to incorporate into the legal framework those rights that are articulated and protected outside the national space, and those that might exist in the future. Hence Article 33 (5)¹¹ of the Constitution stipulates that the human rights and freedoms spelt out in chapter 5 of the Constitution are not exhaustive but more importantly all rights considered to be inherent in a democracy and intended to secure the freedom and dignity of man are also guaranteed. This constitutional provision has an important implication for health care law in Ghana. We submit that by effect of Article 33(5) of the Constitution any right relating to health care recognized in other democracies considered necessary for ensuring dignity of man may be enforced in a Ghanaian court despite absence of explicit domestic legislation. Furthermore, patients' right to access medical records, which is an aspect of the right to health, can be grounded on Article 21(1)(f) of the Constitution which guarantees "the right information, subject to such qualifications and laws as are necessary in a democratic society". The right to privacy guaranteed under the Constitution could arguably be interpreted to encapsulate privacy of health records and protection from arbitrary disclosure of medical records of patients by health care workers.¹² The Human Rights Division of the Ghana High Court has affirmed the patient right of access to her medical records in *Elizabeth Vaah v Lister Hospital and Fertility Centre* (Unreported but the suit number is HRCM 69/10). On 18th May, 2010 the applicant Elizabeth Vaah by motion invoked the jurisdiction of the court pursuant to articles 21 (1)(f),33(1) of the 1992 Constitution and Order 67 of the High Court (Civil Procedure)Rules,2004 for two main reliefs. First, the applicant sought a declaration that a patient is entitled as a matter of right to his or her medical records within the custody of a health service institution subject only to the payment of reasonable fees for the production of copies of the record and any other limitations as recognized law and notwithstanding that the patient made statements in public media. Secondly, the applicant also prayed for an order compelling the respondent, Lister Hospital, to furnish the applicant with her medical records in the custody of the respondent. The factual matrix that precipitated this suit was that the applicant, who was an expectant mother, began receiving antenatal services from the respondent with a view to delivery at respondent hospital. Several tests and scans ran on the applicant and the baby, proved that the mother was carrying a healthy fetus and the baby was perfectly normal. In the course of time the applicant's membranes ruptured and she was rushed to the respondent hospital without delay .The next day the applicant gave birth to a fresh still-birth baby. A post mortem examination revealed that the applicant's baby died of "multiple organ haemorrhages most probably due to a bleeding diasthesis/coagulation defect with bleeding precipitated by "trauma "of labour ". The applicant deposed in the accompanying affidavit to the application that she needed access to her medical records at the respondent hospital so that she could put them at the

disposal of any doctor who attends to her (whether in or outside Ghana) when she plans to have another baby in future. The respondent refused the request for the medical records when applicant solicitors wrote to the hospital. The applicant thus invoked the assistance of the court complaining that her fundamental right to information as guaranteed under article 21(1) (f) of the Constitution had been and was still being violated by the respondent. Article 21(1)(f) of the Constitution states that “all persons shall have the right to information, subject to such qualifications and laws as are necessary in a democratic society.” The defences put up by the respondent were two fold. In the first place, the respondent argued that it was justified in refusing applicant access to the medical records because by speaking to the press about circumstances in which she gave birth at respondent hospital she had evinced intention to abuse the records. The other line of defence canvassed by the respondent was that it was only an order of a court or MDC which could compel it to hand over the medical records. The court analysed the provision in article 21(1) (f) and held that the two grounds canvassed by the respondent were not covered by the qualifications contemplated by the constitution for limiting the freedom of information. Due to absence of any Ghanaian precedent the judge cited and discussed the American cases of *Emmet v Eastern Dispensary and Casualty Hospital*¹³ and *Julian Cannel v The Medical and Surgical Clinic*.¹⁴ Despite the paucity of judicial decisions on human rights dimension of health care delivery in Ghana the *Elizabeth Vaah’s case* is a good indication of how the courts will react to human rights enforcement action by patients. The onus is now on the legal community in Ghana to be interested in framing patients’ complaints as human rights cases.

B. PAKISTAN

Legislative Framework for Health

The Constitution of Pakistan, unlike many other constitutions of the world,¹⁵ does not expressly address the issue of health in its chapter on fundamental rights. While it set forth other individual rights, such as right to fair trial, security, etc, the phrase ‘right to health’ does not appear in the text of the constitution. However, Article 38 clause (d) of chapter on Principles of Policy mention that for the promotion of social and economic well-being of the people

The State shall_____

Provide basic necessities of life, such as food, clothing, housing, education and *medical relief*, for all such citizens, irrespective of sex, caste, creed or race, as are permanently or temporarily unable to earn their livelihood on account of infirmity, sickness or unemployment. [emphasis added]

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The object of this clause is to provide basic necessities of life including medical relief for those citizens of the state who are **permanently** or **temporarily** unable to obtain such necessities on various accounts such as infirmity, sickness etc.

In Pakistan, until recently the federal government enjoyed legislative and executive role in several sectors of state governance. This role has been significantly altered through the 18th amendment to the Constitution ¹⁶. The areas of joint provincial/federal responsibility were listed in the Concurrent Legislative List (CLL) prior to 18th amendment. The CLL has now been abolished and many areas that were previously the responsibility of federal government, including health, have become a provincial subject. The functions and responsibilities of the federal and provincial government have been significantly defined by the 18th amendment to avoid overlapping. The 18th amendment has expanded the provincial domain by devolving various powers to provinces and by greatly curtailing the mandate of federal government. The major purposes are to achieve enhanced provincial autonomy and empowerment. To this end federal level resources are transferred to the provinces and they are given free hand in decision making and management of funds. These measures intends to improve service delivery and administrative control over various sectors by bringing governance and basic services such as food, agriculture, education health etc closer to the people. After 18th amendment 17 federal ministries have been abolished, including health ministry (PILDAT, An Analysis: Health and the 18th Constitutional Amendment). The fact that the country does not have a health ministry at federal level makes Pakistan a unique example among the federal states. However, federal government still have constitutional mandate in certain areas of health, such as interprovincial coordination, health regulation, global health, health information, trade in health, overarching policy norms and health financing (PILDAT, An Analysis: Health and the 18th Constitutional Amendment). In order to consolidate diverse health activity, National Health Services, Regulation and Coordination Division (NHSRCD) has been established which will work under the direct control and command of the federal government.

The Courts' Jurisprudence

There is a growing recognition of the fact that the concept of right to health is inherent in the well established fundamental right to life in various national jurisdictions (Bansal, n.d.). In Pakistan, the right to health has not been addressed directly by the courts, it has rather been approached through a progressive interpretation of right to life laid down in article 9 of the Constitution of Pakistan which states that

‘No person shall be deprived of life or liberty save in accordance with law’

The land mark *Shahla Zia* case provided the Supreme Court with opportunity to offer expansive interpretation of the word ‘life’ mentioned in article 9. Through combined reading of Article 9 (right to life) and article 14 (right to dignity) the court concluded that right to life encompasses the preservation and protection of environment. The Court did not merely recognise that the right to clean, safe and unpolluted environment is integral to the concept of healthy life it rather placed the environmental concerns at the heart of right to life. Arguably, the right to life can be properly realised only when essentials conditions for human survival and dignity are met. While focusing on the protection of environment as a necessary precondition for life, the court clearly highlighted the damaging effects of environmental pollution on the quality of life. This approach is also in line with General Assembly Resolution 45/94 which states that [a]ll individuals are entitled to live in an environment adequate for their health and well-being.¹⁷

The rule that sees clean and unpolluted environment as an essential aspect of life had also been followed in few other cases in the past two decades (Syed Mansoor Ali Shah v Government of Punjab , 2007). However, in *Mohammad and Ahmad* case (Mohammad and Ahmad, 2007) article 9 is interpreted in another way to highlight the responsibilities of the state regarding protection of the lives of its citizens. The Lahore High Court in this case categorically stated that right to life should not be understood in a restrictive sense. The responsibility of state is not limited to merely refraining from wilfully taking the life of its citizens. In any welfare state it is also the responsibility of government to provide appropriate medical facilities to those in need of medical attention within its jurisdiction (Mohammad and Ahmad, 2007: 357). The court concluded that preservation of human life is the major obligation of state and any failure of the medical staff in government hospitals to provide adequate medical attention to the persons in need is tantamount to violation of right to life provided for by the constitution of the state.

In the above case the court clearly and strongly assert that while dealing with medical emergency, where life of citizens is at peril, state should respond responsibly and effectively and should take every possible measure to avert that danger and save people’s lives. Although the court in the above decision has mostly focused on the responsibility of the state in times of medical emergency, it does not address right to life in terms of public healthcare in general, however, this idea can be further expanded to include the obligation of the state regarding the provision of healthcare facilities to all its citizens.

Challenges in the Health Sector

The effective delivery of health services is considered to be essential for the well being of a country's population. The health status of a nation is a useful indicator that helps gauge the social progress of any country. Significant efforts, targeted at policy reforms in the Health care sector, have been made in various countries in the past two decades (<http://www.hsph.harvard.edu/ihsgh/healthsector-reform.html>). Increased emphasis on the idea of welfare state, respect for human rights as a necessary precondition for democratic state and elevation in the status of Social and Cultural rights (after 1993 Declaration of Human Rights) from their previously inferior position of second generation rights, can arguably be cited as possible reasons for the increased focus on policy reforms in the health sector. Health is one of the core areas of social policy in many countries, and the states which have ratified ICESCR particularly have to fulfil their international obligations by taking necessary measures in this area. The initiatives taken on international and national levels, in part, have led to the increasing visibility of health care rights and to establish state obligation to attend to health needs of its citizens.

Country's commitment for delivering health services in terms of the international human rights standards, which apply to the human right to health, can primarily be assessed by the government expenditure for health. It is not possible for the health care system to provide health goods and services with poor health financing. State's expenditure on health according to its GDP varies from country to country depending upon the resources, priority to health and the commitment of government for achieving targets in the area of health. Denmark, Norway and Netherland are among the countries with the highest health expenditure per capita (<http://www.mapsofworld.com/thematic-maps/health-care-expenditure-per-capita.html>). Pakistan, being a low income country with vast social and health inequalities, the health of a huge portion of population is negatively affected due to malnutrition, lack of access to potable drinking water and appropriate sanitation facilities. Arguably, major cause of poor health is rooted in social inequality and economic deprivation. That said, Pakistan's spending on health care presents rather a gloomy picture. In the current fiscal year 2013-14 Pakistan has earmarked 0.8 % of its GDP for health, (UNDP Report, 2013) this is less than all other countries in South Asian region and most nations in the world. This government spending is also far less than the internationally recommended amount of 60 dollar per capita on health care (Health System Financing: the Path to Universal Coverage, 2010). This extremely inadequate budget allocation can hardly meet the health needs of country's 180 million people. Moreover Pakistan has no national health insurance system and almost 78 percent of the population pay

health care expenses themselves (http://reliefweb.int/report/pakistan/challenges-improving-health-care-pakistan, 2013). Health coverage is available only to limited categories of people, such as employees of government/semi government, private companies or people working in certain types of formal sector. In these cases healthcare benefits are usually provided in the form of social security, maternity benefits, or reimbursement etc. The general population in is not entitled to healthcare.

Admittedly, reforming a healthcare system of a country, particularly of a less developed one with limited resources such as Pakistan, is not a straightforward task (Dragger, 2000). Any implementation of country's health care system improvement project involves, *inter alia*, adequate resources, reliable data, negotiations and decision making at multiple levels and stages and clear focusing on priority areas. A number of factors contribute to the development and effective implementation of a comprehensive, viable and efficient health policy. It requires not only the energies, insights and collaborative efforts of a team of professionals and seasoned experts in ancillary fields but also their ability to skilfully conduct negotiations with funding authorities, both national and foreign, throughout the process of decision making. When the health care policy decisions are made on the basis of correct data/ information and by carefully choosing between various priorities then such decision can arguably produce meaningful outcomes.

Right-Based Approach: Human Right to Health

The civil and political rights, that are usually categorized/guaranteed as fundamental rights in various constitutions, including Pakistani constitution, were traditionally given precedence over the rights that were of economic and social nature (Quane, 2010). The division between two types of rights appearing in Pakistan Constitution, or similar distinction contained in some other world constitutions, is identical to the one that was maintained between International Covenant on Civil and Political Rights (ICCPR) and International Covenant of Economic Social and Cultural Rights (ICESCR) until early 1990ies (Justiciability of ESC Rights: The Indian Experience). The rights embodied in ICCPR were historically, and to some extent still are, perceived as superior, and called as first generation rights (Ruppel, 2008). Those that are contained in ICESCR were non-justiciable, traditionally treated as goals to be progressively realized by the state and were called as second generation rights. However, in the world conference on human rights held in 1993, the rights enshrined in the two multilateral treaties were recognized and declared as interdependent, indivisible and inter-related (Quane, The Interdependence and indivisibility of Human Rights, 2010). In the following decade a number of states incorporated health care rights in their legal framework either by

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inserting clauses expressly stating right to health care in their respective constitutions, or through judicial process by expansive interpretation of the fundamental rights such as right to life¹⁸. On international and regional level a number of core human rights instruments recognise the right to health¹⁹. The human rights based approach requires the fulfilment of four interrelated criteria to ensure the effective realisation of right to health, i.e, Availability, Accessibility, Acceptability and Quality (AAAQ) (CESCR, General Comment 14). AAAQ includes availability of healthcare facilities, goods, services and programs; easy access to health care facilities/services by removing physical and structural barriers and discrimination; culturally and ethically acceptable health care system; and medically/scientifically appropriate quality of health care system.

The existing legislation in Pakistan relating to healthcare is piecemeal and is meant to deal with specific situations/persons. Instead of adopting right-based approach the country has attempted to achieve targets in the health sector through policy. Arguably, mere entitlements rooted in policy can neither establish a right nor can assure equity. The human rights approach offers an ethical benchmark to evaluate all policy decisions and actions of state. However this approach, particularly in the area of health, is under developed in Pakistan.

Since Pakistan has ratified the ICESCR and many other international human rights instruments of direct or implicit relevance to health, (CEDAW, WHO) it is recommended that the subject of health should be contextualised in the universally accepted framework of human rights. Human rights norms provide standards by which the conduct of the state can be judged and it can be held accountable for not meeting these standards. This approach would also contribute to the improvement of the quality of democracy in the country. Under human rights approach health care system can be reconceptualised as a social system rather than a mere service providing mechanism. Human rights based approach will go beyond the mere requirement of minimum standards of care and will focus on the determinants of health, such as food, clean drinking water, sanitation etc. It will also provide framework of protection against environmental pollution and work place hazards. Moreover, understanding health in terms of human right will increase the accountability of state towards its citizens. The right-based approach will provide the due diligence standard, an important and well established framework of human rights law, against which the performance of state obligation can easily be evaluated. The concept requires states to implement all possible and reasonable measures in three major areas, i.e, prevention, protection and reparation. Under this standard states are bound to comply with their human rights obligations. The legal and human rights community in Pakistan can

creatively draw on the cumulative and derivative effects of the provisions of international instruments to advance the right to health care.

Conclusion

The exercise we undertook into the right to health under international and municipal law has charted significant points. Health has universally been recognised as an important dimension of human flourishing. This has been recognised at the global and regional level by protection of the right to health/health care in international human rights instruments. The content of this right has been explored and explicated within the context of the major international human rights instrument enshrining the right to health. Apart from international human rights instruments, municipal legal systems also recognise the right to health explicitly or tacitly. The article argues that Ghana and Pakistan still have to go long way to adopt human right based approach in the area of health. While some measures have been taken on policy level in the past few years, however, the process is very slow and requires strong will/commitment both on the part of policy makers and judges.

Notes

1. UN Universal Declaration of Human Rights, G.A. Res. 217A (III), art. 13.1, U.N. GAOR, 3d Sess., at 71, 74, U.N. Doc. A/810 (1948). (hereinafter, UDHR)
2. See The chapters on Fundamental rights and Principles of Policy in the Constitution of Pakistan 1973
3. International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), U.N.
4. International Covenant on Economic, Social and Cultural Rights, G.A. Res. 22001 (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316, 993 U.N.T.S. 3 (1966). (hereinafter ICESCR). Article 12 stipulates:
 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;

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- (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
5. International Covenant on Economic, Social and Cultural Rights, G.A. Res. 22001 (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316, 993 U.N.T.S. 3 (1966). (hereinafter ICESCR). Article 12 stipulates:
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 - (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
6. International Convention on the Elimination of All Forms of Racial Discrimination, Dec. 21, 1965, art. 5(d)(vii), G.A. Res. 2106 (XX), U.N. GAOR, 20th Sess., Supp. No. 14, at 47, U.N. Doc. A/6014 (1965), 660 U.N.T.S. 195, 222 (*entered into force* Jan. 4, 1969).
7. Convention on the Elimination of All Forms of Discrimination Against Women, Dec. 18, 1979, art. 12, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, U.N. Doc. A/34/36 (1980) (*entered into force* Sept. 3, 1981)
8. Convention on the Rights of the Child of 1989, Nov. 20, 1989, art. 24, G.A. Res. 44/25, U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc A/44/49 (1989) (*entered into force* Jan. 4, 1969)
9. African [Banjul] Charter on Human and Peoples' Rights, adopted June 27, 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), entered into force Oct. 21, 1986 (hereinafter 'the African Charter')
10. Article 34(2) stipulates: "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.”

11. The full text of Article 33(5) states: “The rights, duties, declarations and guarantees relating to the fundamental human rights and freedoms specifically mentioned in this Chapter shall not be regarded as excluding others not specifically mentioned which are considered to be inherent in a democracy and intended to secure the freedom and dignity of man.”
12. See Article 18 (2) of the 1992 Constitution which stipulates “No person shall be subjected to interference with the privacy of his home, property, correspondence or communication except in accordance with law and as may be necessary in a free and democratic society for public safety or the economic well-being of the country, for the protection of health or morals, for the prevention of disorder or crime or for the protection of the rights or freedoms of others.”
13. 130 US App D.C. 50 ,396 F 2d 931 [1967]
14. 21 I 11 App.3d 383,315 NE2d 278 [1974]
15. Such as Indonesia, Thailand etc see WHO: 2011, The Right to Health in the Constitution of Member States of the World Health Organisation South-East Asia Region’ p. 2
16. See generally The Constitution of the Islamic Republic of Pakistan 1973
17. 1990 UN-General Assembly Resolution A/Res/454/94
18. For example India, See Balakrishnan, K.G., 2008,Chief Justice Address in National Seminar on Human Right to Health’ Matsuura, Hiroaki, 2013, The Effect of a Constitutional Right to Health on Population Health in 157 Countries 1979-2007: The Role of Democratic Governance , Working Paper no.16
19. Art. 25 the UDHR , Art. 12 of the ICESCR, General Comment 14 of the Committee on Economic Social and Cultural Rights, Art. 24 of CRC, Art. 12 of CEDAW, Art. 5 (e) iv of ICERD, Alma Ata Declaration

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