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# **The Right to Health Care in International Law**

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**Submitted in fulfilment of the requirement for the**

**Degree of Doctor of Philosophy in Law**

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**UNIVERSITY  
of  
GLASGOW**

**February 2013**

# Abstract

Health is an important matter for both individuals and states. Since the adoption of the Universal Declaration of Human Rights 1948 (UDHR), health has been categorised as a human right. In the years following this Declaration, many international treaties and national constitutions have emphasised this issue; for example, article 12 of the International Convention of Economic, Social and Cultural rights 1966 (ICESCR). However, as this thesis notes, the language in which this right is cast varies. This, it is argued, is problematic for any attempt to vindicate the right and ensure its justiciability. Accordingly an alternative definition is explored and clarified in what follows.

In first chapter, the focus is on arguing that, the current phrases such as ‘right to health’, ‘right to medical care’, ‘the human right to highest attainable standards of health’ and ‘right to health protection’ are vague and weak and may prevent a clear understanding of the expectations that people may legitimately have. The main outcome is to describe a workable and more precise right which can also be legally enforced; that is, the right to health care.

In the second chapter, the legal sources of the right to health care in international law are explored. In particular, it is argued that there are obligations on states to implement this right and, as members of the international community and the main subject of international law, to take all necessary steps to put it into practice by translating these obligations into domestic law, thus ensuring that health care is treated as a human right. In addition, this chapter also describes the general principles of human rights, such as non-discrimination, participation and equity, that ought to be taken into account by the state’s authorities when they implement the right in question.

The following two chapters are devoted to examining the status of the right to health care in the United Kingdom and Libya as models of developed and developing countries. According to health Act No 106 of 1973, health care appear to be simply human right in theory in both national law and international commitments however in practice the government as well as the judiciary did not take it seriously. As result, the case laws have not considered such right as human right nor a legal right for Libyans.

In the UK, the reluctance of the government to treat health care as legal right has not stopped judges to evaluate health decisions makers and adjudicate whether such decisions were proper with the case in question. Thus, the chance for UK citizens to review the

decisions of the health authorities is wider under the judicial review in terms of legal right rather than human right.

In the conclusion, it is proposed that the main problem in according the right to health care the status of a human right is not in fact related to any inability of the judiciary to deal with social and economic rights, nor is it reliant on disagreement about the legal nature of the right and whether it should be categorised as a negative or a positive right, but relates rather to the meaning of the right and what it should include. It is further proposed that the right defended in this thesis – the right to health care – can solve this problem by clarifying the nature and content of the right. The UK experience shows that when such clarity exists, the debate about whether or not the right exists or is justiciable becomes irrelevant. Equally, the state can ignore the international distinctions between types of right and invest health care with the status of a justiciable right in domestic law. While the interim Libyan Government refers to a right to health care in its new constitution, it is clear that political will is necessary to translate it into reality. The Libyan state has much to learn from the healthcare and legal structures of the United Kingdom; particularly it can learn from examination of the mechanisms by which the UK, and other European nations and organisations, have effectively avoided the debate about whether or not the right to health care can be categorised as a human right by developing jurisprudence that renders it clear and justiciable in and of itself.

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The South African Constitution 1996

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# Dedication

In Memory of My grandmother...Fatima Imjihid 2004,  
My Mother ... Aisha Alsanousi 2011

&

My Father...Moftah Elalam 2010

And in memory of all youth Libyans who dead for freedom of Libya and  
for better future to all Libyans

# Acknowledgement

I would like primarily to thank Professor Sheila McLean and Professor Jim Murdoch my Supervisors, whose expert knowledge and leadership assisted me greatly, and which I learned a lot from. Their excellent advice, thoughtful comments and knowledgeable guidance during my research study and writing were invaluable. My grateful thanks to Professor Sheila not only for her guidance, advice and supervision, but also for the fact that she has believed in my abilities and thus kept me motivated and encouraged me on my PhD path. Her professional, positive and encouraging attitude has influenced both my PhD research and my academic career and I believe will keep influencing me in future. She has greatly formed my academic future for which I cannot express enough appreciation.

I would like to thanks librarians in University of Glasgow, Law school workshop, Benghazi Law school library and Benghazi Appeal Court library especially Dr Kay Munro, Mrs Ellen Gallagher, Mr Bulkasim and Kiria Buznad for their help whenever I asked.

This is also good opportunity to express my teachers and lecturers, since primary school till master degree, whose always encouraged and supported me to keep going till this stage especially Abdelkader Kadora, Abdalkader Shihab, Ahmad Elghani, Ahmad Buzgaia, Sulieman Algroschi, Gith Alfakeri, Omar Alsiway, Salem Aloujali, Musa Rhoma and Omran Imhamid.

I would also like to thank my friends within and outside of the University, and the staff at the Registry and library. They were all very kind to me during the time when I studied in Glasgow. In particular, I want to express my thanks to Omar Alghmasi, Ahmad Habib, Taher Galid, Nasser Darnawi, Sabri Gargali, Fathi Ali, Sulieman Mohamad and Aiad Bukrim for their sincerely friendship.

I am indebted to Ministry of Higher Education and University of Benghazi in Libya for providing me with the scholarship that allows me to study in the UK. My special thanks go to Mr Mohammad Ibrahim, director of health information centre in Libya, for giving his time, and providing health information.

I am also grateful to my good friends; most notably Elsdik Elfarsi, Esam Ben Gashir, Othman Rofa, Noralaslami Trapilsa and their family encouragement and friendly heart have supported me through my ups and downs. Especial thanks also to Dr Aziza Elmesmari who

constantly accompanied me on my PhD journey with strong belief in my abilities with my best wishes in her life and her PhD. My final and important thanks belong to my great family, brothers and sisters, for their unconditional love and support especially in moments when I had to face different life difficulties..... *Thank you all*

Responsibility for all arguments and errors remains, of course, mine.

## **Author's Declaration**

All investigations in this thesis were undertaken by the author under the supervision of Professor Sheila McLean and Professor Jim Murdoch within the School of Law University of Glasgow from May 2006 until November 2012.

Signature: -----

Printed Name:-----

# Definitions/Abbreviations

Af CHPR	African Charter on Human and Peoples' Rights
AfCHR	The African Court of Human and Peoples' Rights
AfCJ	The African Court of Justice
AfCJHR	The African Court of Justice and Human Rights
AU	African Union
BPsC	The Basic People's Congresses
CEDAW	International Convention on the Elimination of All Forms of Discrimination against Women
CESCR	The Committee on Economic, Social and Cultural Rights
ICESCR	International Committee on Economic, Social and Cultural Rights
CRC	Convention on the Rights of the Child
DGH	The District General Hospital
DHAs	The District Health Authorities
ECHR	European Convention of Human Rights
ECJ	European Court of Justice
ECOSOC	The Economic and Social Council
ECSC	European Coal and Steel Community
ECSR	The European Committee of Social Rights
ECtHR	European Court of Human Rights
EEC	European Economic Community
ESC	European Social Charter
EUCFR	Charter of Fundamental Rights of the European Union
EURATOM	European Atomic Energy Community
GAR	General Assembly resolutions
GPC	General People's Congress
GPs	General Practitioners
HRC	Human Rights Committee
ICCPR	International Convention of Civil and Political Rights
ICESCR	International Convention of Economic, Social and Cultural Rights
ICESCR	International Committee on Economic, Social and Cultural Rights
ICJ	International Court of Justice
ILO	International Labour Organisation

MHRA	Medicines and Healthcare Products Regulatory Agency
MoH	The Ministry of Health
NHS	The National Health Service
NHS Act	National Health Service Act of 1946
NICE	National Institute for Health and Clinical Excellence
PAHO	Pan American Health Organization
PCTs	Primary Care Trusts
RCC	The Revolutionary Command Council
RGA	Resolution of the General Assembly
SAfCJHR	The Statute of the African Court of Justice and Human Rights (the Statute)
UDHR	Universal Declaration of Human Rights
UN	United Nations
UN charter	United Nations Charter
UN GA	General Assembly of the United Nations
WHO	World Health Organization

# **Chapter I: Definition of the Right to Health Care**

## 1.1 Introduction

Health is in general a complicated concept that can be affected by many external influences, for example, political, economic and cultural. In addition, health is a fundamental precondition for the enjoyment of one's human rights. However, while there is general agreement that health is essential for 'human flourishing' and its importance in the attainment of other rights,<sup>1</sup> attempts to claim a *right* to health face problems in terms of both definition and classification. However, as health features in a number of international human rights declarations, it is appropriate at this stage to explore the implications of this. The question of the nature of any right identified will be further explored in chapter 4.

In terms of international law, health has been considered as a problematical matter because of several issues, such as the history of human rights in general, the nature of human rights and the language in which these rights are couched. Thus, there is no agreement about the concept of the right to health or its content or even in which set of human rights it should be listed, if it can be considered as a right at all. Although, the right to health is referred to in a number of human rights conventions, its status as a full right is less than clear, as is its content.

At this stage, it is important to explain that this thesis will attempt to clarify the concept and its contents in a way that identifies its importance in terms of the enjoyment of other rights, such as the right to life, even if ultimately it cannot be classified as a fundamental human right in international law. Thus, the issue is not specifically to argue that a legal right, as understood by international human rights law exists, but rather to identify a legally protectable interest and its contents, to evaluate its fundamental significance and to argue that it is possible to recognise rights in this area which are vindicable by citizens against states. Thus, even although, as will be seen, there may be uncertainty about the status of any claimed 'right to health' in international law, it will be argued that the importance of health (or health care - the concept that will be argued for here) is such that it must be more than aspirational and that governments have an obligation, demonstrated by their

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<sup>1</sup>B.M. Meier, "Highest Attainable Standard: Advancing a Collective Human Right to Public Health, The," *Colum. Hum. Rts. L. Rev.* 37(2005).120, see also B. Toebes, "Towards an Improved Understanding of the International Human Right to Health," *Human Rights Quarterly* 21, no. 3 (1999).. 3

commitment to a number of international agreements, to ensure the best available provision of health (care) for their citizens.<sup>2</sup>

In order to consider this, chapter I of this thesis will be divided into four sections. The first section will focus on human rights in general. A brief history of human rights particularly since 1945 will be explored, as will how this led to the separation of human rights into two sets. In section two, an evaluation will be undertaken of the expressions or terms that have been used in academic and international documents to identify and define health as a human right and of whether these definitions are appropriate to meet the expectations of citizens in general and patients in particular. The third section will highlight the main problem of establishing a right to health. The final section will elucidate a concept of a right to health(care) that is compatible with reality. The thrust of the argument is to demonstrate that, irrespective of its status in terms of traditional international law, any such right is justiciable and therefore – like other rights – can be vindicated. Until these issues have been clarified and analysed, the term ‘right to health’ will be used, although as will be seen, this language will be critiqued in some depth. For the moment, until the appropriate term has been identified, it should be taken as a shorthand version of what any such right might actually entail.

## **1.2 Human Rights: History and Nature**

### **1.2.1 Introduction**

Although the right to health has been listed in the International Covenant on Economic, Social and Cultural Rights ICESCR alongside other socioeconomic rights its status is still arguable. Many of the ICESCR rights have been recognized by the international community as full human rights. However, unlike other human rights such as education, there are still difficulties in terms both of the recognition and the enforceability of the right to health.<sup>3</sup>

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<sup>2</sup>E. Palmer, *Judicial Review, Socio-Economic Rights and the Human Rights Act (Human Rights Law in Perspective)*, 1 ed. (Hart Publishing, 2007).14-16

<sup>3</sup>In this issue see the comment by who states that “ICCPR including rights such as freedom of expression and freedom of conscience is implemented by means of compulsory reporting system and optional inter-state and individual complaints. The ICESCR contains rights which impose greater positive obligations upon the states, such as a right to housing and a right to food, and their implementation is therefore more controversial, especially in many Western states”. D.J. Whelan and J. Donnelly, "The West, Economic and Social Rights, and the Global Human Rights Regime: Setting the Record Straight," *Human Rights Quarterly* 29, no. 4 (2007)..A.B. PEREIRA, "Live and Let Live: Healthcare Is a Fundamental Human

It is important to consider the nature of human rights in general before going on specifically to address the subject of this thesis, namely, the 'right to health'. This discussion will explain why human rights are so important and how they can be delivered to people. Most importantly, discussion of the nature of human rights will lead to consideration of two main questions. First, is the question of whether they are legal rights or not. In other words, if human rights are so important and they result in obligations, what sort of obligations will be derived from such rights and will these obligations have the same value? The second question relates to the first question. If these rights are legal obligations or legal rights who is responsible for providing them, who should be their recipient and how should such rights be delivered?

In this section, the discussion will be divided into three subsections. The first subsection will illustrate the development and history of human rights. In particular, it will highlight the main developments that have occurred since World War II.<sup>4</sup> More specifically, it will show how and why the international community adopted the Universal Declaration of Human Rights (UDHR), the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) which, taken together, are referred to by international lawyers as the International Bill of Human Rights.

The second subsection will describe the nature of human rights and their importance for human beings in general. Furthermore, the characteristics of human rights will be explained in order to explore how human rights are articulated. This subsection will also attempt to establish whether or not there are significant differences between the two sets of human rights described above, in terms of legality and implementation. In the third subsection, the two sets of human rights will be considered in terms of their effect and the consequences of the separation of human rights into two sets will be considered in order to explain how the nature of human rights has been affected by this separation, especially in regard to the legal status of right to health listed in the ICESCR

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Right," *Conn. Pub. Int. LJ* 3(2004). Also see S. P. Marks, "Past and Future of the Separation of Human Rights into Categories," *Md. J. Int'l L.* 24(2009).

<sup>4</sup> See an article by legal division, "The Application of International Human Rights Standards in Domestic Law," *Victoria University of Wellington Law Review* 22, no. 3 (1992 ). 1

## 1.2.2 The History of Human Rights

At the outset, it is important to note that the history of human rights could be said to go back for as long as humans have been on the earth. Alternatively, one could hold that the history of human rights can be traced back to the appearance of the modern state, or at least to Hobbes's theory which considered the relationship between state and citizen<sup>5</sup> or to the writings of John Locke.<sup>6</sup> As pointed out by Eide, Locke was the first writer to discuss rights as an integrated element in the concept of the modern political system;<sup>7</sup> therefore, human rights can be traced at least to the French and American Revolutions of the late 1700s.<sup>8</sup> But for the purposes of this study the focus will be on the history of human rights since the end of the Second World War.<sup>9</sup> In an international sense, human rights became a substantive component of the new international law that followed that conflict. Human rights are an international concern and there is a common duty on the United Nations and its Member States to promote universal respect for, and observance of, human rights and fundamental freedoms for all, without distinction as to race, language, religion or sex.

In 1945, at the start of a new international order, the Allies looked for new goals that could give the world population new hope and aspirations, and, of course, help them to forget the disaster of the war which had killed and injured many millions as well as having other negative social and economic effects.<sup>10</sup> For this reason, it seems that governments tried to elevate the concept of human rights in order to create a new international legal system where human beings were offered protection. Indeed, this was an important step which made the promulgation and protection of human rights one of the main purposes of the United Nations (UN). Under article 1 (3) of the United Nations Charter, UN member states are required to work to promote and encourage respect for human rights and fundamental freedoms for all, without distinction as to race, sex, language, or religion; and most

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<sup>5</sup>R. P. Peerenboom, "Human Rights and Rule of Law: What's the Relationship?," *bepress Legal Series* (2004). 1

<sup>6</sup>About the role of John Locke in human rights see Daphne Barak-Erez and Aeyal M Gross, Do we need social rights, questions in the era of globalization, privatisation, and the diminished welfare state in E. Daphne Barak and A M. Gross, *Exploring Social Rights* (Hart Publishing, 2007). 1

<sup>7</sup>A. Eide, C. Krause, and A. Rosas, *Economic, Social and Cultural Rights: A Textbook* (M. Nijhoff Publishers, 2001).

<sup>8</sup>A. Eide and A. Rosas, "Economic, Social and Cultural Rights: A Universal Challenge," *A. Eide et al., Economic, Social and Cultural Rights. Dordrecht/Boston/London: Martinus Nijhoff Publishers* (1995). 3

<sup>9</sup>In relation to the impact of the Second World War on human rights see W. Kalin and J. Kunzli, *The Law of International Human Rights Protection* (Oxford University Press, USA, 2009). 1R. Bilder, "An Overview of International Human Rights Law," *GUIDE TO INTERNATIONAL HUMAN RIGHTS PRACTICE, 4th Ed., Hurst Hannum, ed* (2010). 4

<sup>10</sup>division, "The Application of International Human Rights Standards in Domestic Law."

importantly, they promise to make these purposes central to the harmonisation of the actions of nations in the attainment of these common ends.<sup>11</sup>

In 1948, the first step toward universal human rights was taken by the General Assembly of the United Nations when it adopted the Universal Declaration of Human Rights. (UDHR)<sup>12</sup> Although the Declaration was non-binding,<sup>13</sup> there was agreement about its importance as the first actual step in recognizing the universality of human rights.<sup>14</sup> In addition, there are writers who strongly argue that the UDHR is in fact a binding instrument and that there is no reason to see it as anything else. For instance, Sohn considers this document, together with the Charter, as being part of the constitutional structure of the world community rather than only as a part of customary international law.<sup>15</sup> Whatever its true status, the UDHR has played a fundamental role in promoting human rights as one of the essential goals for human beings in the current era. Furthermore, the UDHR paved the way for further steps in terms of human rights in general. Most importantly for the purposes of this thesis, civil and political rights and social and economic rights were treated as equivalent in the UDHR in terms of their legal status.<sup>16</sup>

At a regional level, the field of human rights has also witnessed important developments, especially in Europe where a rights-based jurisprudence has been developed through decisions of both the European Court of Human Rights and the European Court of Justice. The development of human rights in Europe has also had a positive influence in other regions of the world. In Africa, for instance, the African countries adopted the African(Banjul) Charter on Human and Peoples' Rights in 1981. Similarly, the American states agreed to issue the American Declaration of the Rights and Duties of Man<sup>17</sup> and established the Inter-American Court of Human Rights and Commission.

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<sup>11</sup> The U.N. Charter available at <http://www.un.org/aboutun/charter/index.html> accessed 15/02/2009

<sup>12</sup> The Universal Declaration of Human Rights was issued in 10/12/1948 such document is available at <http://www.un.org/Overview/rights.html>

<sup>13</sup>In this regard Jackman has considered the Declaration as a general statement of principle see her article M. Jackman, "From National Standards to Justiciable Rights: Enforcing International Social and Economic Guarantees through Charter of Rights Review," *JL & Soc. Pol'y* 14(1999). 73

<sup>14</sup> Reference of binding sees also L. B. Sohn, "New International Law: Protection of the Rights of Individuals Rather Than States, The," *Am. UL Rev.* 32(1982).. 17

<sup>15</sup>ibid.16-17

<sup>16</sup>S. B. Shah, "Illuminating the Possible in the Developing World: Guaranteeing the Human Right to Health in India," *Vand. J. Transnat'l L.* 32(1999).442

<sup>17</sup>The American Declaration of the Rights and Duties of Man. 1948 available at [http://www.oas.org/DIL/American\\_Declaration\\_of\\_the\\_Rights\\_and\\_Duties\\_of\\_Man.pdf](http://www.oas.org/DIL/American_Declaration_of_the_Rights_and_Duties_of_Man.pdf) accessed 15/02/2009

Although the adoption of the Human Rights Bill by the UN General Assembly has done a great deal in terms of the universalisation of human rights, the international community - including the UN - has failed to bridge the gap between the theoretical and the practical aspects of human rights. In spite of the recognition of the importance of human rights by the international community, ideological differences that existed in the aftermath of the 2<sup>nd</sup> World War resulted in the separation of human rights into two types. The first is that of political and civil rights,<sup>18</sup> which were supported by the Western states. The second is that of economic, social and cultural rights,<sup>19</sup> which were supported by the Eastern world and developing countries.

With regard to this separation of human rights into different categories, there are two issues that have to be explained. Firstly, this separation has impacted negatively on the treatment of human rights by states. Secondly, and as result of the first point, there is disagreement about the nature of the obligations that are assumed to be generated by different international conventions and whether they are equal in the sense of legal obligations. It seems that there is confusion in states' understanding of the obligatory nature of human rights and this is particularly true in terms of a right to health.<sup>20</sup> There are, for example, commentators who believe that human rights commitments are only those mentioned in the UDHR, the ICCPR and the ICESCR.<sup>21</sup>

In 1966, the UN General Assembly (GA) adopted two human rights covenants<sup>22</sup> the aim of which was to end the discussion about whether the UDHR is a binding or non-binding instrument. However, they appear to have intensified the debate rather than settled it. In terms of history, it is worth noting that the Bill of Human Rights (UDHR, ICCPR and

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<sup>18</sup> Office of the United Nations High Commissioner for Human Rights, International Covenant on Civil and Political Rights, 1966 available on line at <http://www2.ohchr.org/english/law/ccpr.htm> accessed 24/09/2012

<sup>19</sup> Office of the United Nations High Commissioner for Human Rights, International Covenant on Economic, Social and Cultural Rights, 1966 available on line at <http://www2.ohchr.org/english/law/cescr.htm> accessed 24/09/2012

<sup>20</sup> Such confusion can be referenced to the disagreement about the nature of socioeconomic rights between Western countries and the Soviet Union and developing country. For more details about this deviation see Sofia Gruskin and Daniel Tarantola, "Health and Human Rights," in *Perspectives on Health and Human Rights*, ed. Sofia Gruskin et al (eds) (Taylor & Francis Group, 2005).7

<sup>21</sup> E. D. Kinney, "International Human Right to Health: What Does This Mean for Our Nation and World," *Ind. L. Rev.* 34(2000).1459-60 see also E. D. Kinney, "Recognition of the International Human Right to Health and Health Care in the United States," *Rutgers L. Rev.* 60(2007). 337-38, also A.E. Yamin, "The Right to Health under International Law and Its Relevance to the United States," *Journal Information* 95, no. 7 (2005). 1156

<sup>22</sup> United Nations, General Assembly, A/RES/2200(XXI)[A-C] C.3, 62, A/PV.1496 16 Dec. 1966 A/6546 online <http://www.un.org/depts/dhl/resguide/r21.htm> accessed 30/08/2012

ICESCR) is not the only international document in this area, although it is the most important. In fact, there are other international agreements that the UN General Assembly has adopted on human rights but these agreements are more specialised in terms of their subject matter. Good examples of these treaties are the International Convention on the Elimination of All Forms of Discrimination against Women (CEDAW 1979),<sup>23</sup> the Convention on the Rights of the Child (CRC 1989),<sup>24</sup> the Vienna Declaration and the Programme of Action 1993; and there are many others. Most importantly, and as will be explained below, human rights have also been referred to in international agreements that established international organizations such as the Constitution of the World Health Organization.<sup>25</sup>

### 1.2.3 The Separation of Human Rights

On first inspection, it should be clear that the UN did not, and does not, take the view that human rights should be separated into two kinds. In 1966, the statement of human rights provided by the UN General Assembly was contained in one document, which suggests that the UN believed that human rights could not and should not be divided.<sup>26</sup> In reality, the outcome was far from this: there was a political world in existence in which there was conflict between UN members in terms of their ideology. Two distinct opinions emerged: the first believed that political and civil rights should be given priority, in contrast to economic and social rights.<sup>27</sup>

An overview of the libertarian approach to health provides a good framework for understanding the nature of socio-economic rights. In accordance with the libertarian approach, states are not required to accept claims of positive rights whereas they cannot

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<sup>23</sup> The United Nations, General Assembly resolution 34/180 of 18 December 1979 available at <http://www.mineaction.org/downloads/Emine%20Policy%20Pages/HR%20Law/CEDAW.pdf> accessed on 18/03/2010

<sup>24</sup> The United Nations, General Assembly resolution 44/25 of 20 November 1989 available at <http://www2.ohchr.org/english/law/pdf/crc.pdf> accessed 18/03/2010

<sup>25</sup> In its preamble states that "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." Available at [http://www.who.int/governance/eb/who\\_constitution\\_en.pdf](http://www.who.int/governance/eb/who_constitution_en.pdf) accessed 10/03/2010

<sup>26</sup> M.J. Dennis and D.P. Stewart, "Justiciability of Economic, Social, and Cultural Rights: Should There Be an International Complaints Mechanism to Adjudicate the Rights to Food, Water, Housing, and Health?," *American Journal of International Law* (2004).476 see also the UN General Assembly resolution 421 E (V) (Dec. 4, 1950).

<sup>27</sup> This is the opinion of the Western country where the classic freedoms has been given priority to respect see FonsCoomans, Economic, social and cultural rights, SIM, 16, 5 available on line at <http://www.uu.nl/NL/faculteiten/rebo/organisatie/departementen/departementrechtsgeleerdheid/organisatie/institutenencentra/studieeninformatiecentrummensenrechten/publicaties/simspecials/16/Documents/16-2.pdf> accessed 24/03/2010

reject claims in relation to negative rights.<sup>28</sup> In the libertarian view, positive rights require interference in individuals' lives whereas negative rights do not. For this reason, the USA strongly disliked the combination of the two types of human rights in one treaty. As was mentioned above, only political and civil rights are real human rights from the point of view of the American government. In its opinion, political rights do not require positive action from the state. They do not cost the government anything for their vindication. Thus, the rights listed under this heading were seen as legitimate and universal. In contrast, socioeconomics rights are not legal rights; they are only for those who are able to pay for them. Therefore, they are mostly moral and not legal rights.<sup>29</sup> Indeed, there are writers who have demanded that economic and social rights must be removed from the list of human rights. From their perspective, the difficulty of implementing human rights in general can be blamed on the inclusion of socio-economic rights.<sup>30</sup>

On the other hand, there is another group who criticised the separation of human rights into two parts.<sup>31</sup> There is disagreement, for example, about the nature of the actions required of states. The question that has been raised with regard to the implementation of political rights is whether their vindication really is negative rather than positive. Many writers, including some Americans, believe that in order to enforce political and civil human rights,<sup>32</sup> it is not enough for the state to take negative action; rather it is also required to take positive steps.<sup>33</sup> For example, protection of the right to life assumes that a state has to employ and pay for qualified policemen and judges.<sup>34</sup>

In addition, Bole and Bondeson have addressed the difficulty of separating human rights into two groups and the impact of this, though they highlighted the priority of positive rights in certain situations. They state that "this coercive imposition is difficult to justify,

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<sup>28</sup>T. Friesen, "Right to Health Care, The," *Health LJ* 9(2001). 206

<sup>29</sup> About the American view on social and economic rights see B. Stark, "Economic Rights in the United States and International Human Rights Law: Toward an Entirely New Strategy," *Hastings LJ* 44(1992).79-130, see also PEREIRA, "Live and Let Live: Healthcare Is a Fundamental Human Right." 488-489, P. Alston, "Putting Economic, Social, and Cultural Rights Back on the Agenda of the United States," *NYU School of Law, Public Law Research Paper No. 09-35, Center for Human Rights and Global Justice Working Paper No. 22, 2009* (2009)..

<sup>30</sup>J. W. Nickel, "Are Human Rights Utopian?," *Philosophy & Public Affairs* 11, no. 3 (1982). 259

<sup>31</sup>F. Coomans, "Economic, Social and Cultural Rights," *Reports Commissioned by the Advisory Committee on Human Rights and Foreign Policy, SIM Special No 16*(1995).5-6 see also O. Nnamuchi, "Kleptocracy and Its Many Faces: The Challenges of Justicability of the Right to Health Care in Nigeria," *Journal of African Law* 52, no. 1 (2008). And B. C. A. Toebes, *The Right to Health as a Human Right in International Law*, vol. 1 (Hart Pub, 1999). 305

<sup>32</sup>Malcolm N. Shaw, *International Law*, 5<sup>th</sup> ed. (Cambridge University Press, 2003). 249-252

<sup>33</sup>Alan Gewirth, "Are All Rights Positives?," *Philosophy & Public Affairs* 30, no. 3 (2002). 221-333

<sup>34</sup>See generally S. Holmes and Cass R. Sunstein, *The Cost of Rights: Why Liberty Depends on Taxes*, New Edition ed. (W. W. Norton & Company, 2000).

because the burden of proof in establishing which sort of rights should be given the priority over the other in any particular case seems to lie upon positive, not negative rights".<sup>35</sup>

In the case of health, its importance lies in its special role, arguably placing it at the centre of human rights. It has been pointed out that other human rights cannot be enjoyed without health. Meier, for example, has clearly stated that "health is essential for human rights flourishing and the exercise of all other rights".<sup>36</sup> The idea that other rights cannot be fully implemented without health has been affirmed by Toebe.<sup>37</sup> Tamara Harvey has emphasized that implementing social rights is not less important than implementing civil and political rights, arguing that:

I tend towards the view that if the value of civil and political rights is appreciated, it is certainly worth exploring what may be gained by applying the notion of rights to social entitlements such as the 'right to health'. Further, the realization, in practice, of civil and political rights may be rendered meaningless without the means to enjoy them has led some to argue that social rights are higher in value than civil and political rights.<sup>38</sup>

For the purposes of this thesis, and most legal writers, the position is taken all human rights need to be treated as equal in priority and that they are interdependent, indivisible, interrelated and, most importantly, inalienable.<sup>39</sup> The international community, therefore, needs to treat all human rights equally, without distinction between political and social rights or negative and positive rights.<sup>40</sup> For this reason, and others, the treatment of human rights by states should be equal and there is no reason to deal with them separately.. Thus, both sets of rights need the intervention of the state in order to be achieved. The Vienna Declaration stressed this clearly when it provided that "All human rights are universal, indivisible and interdependent and interrelated".<sup>41</sup> The importance of this declaration in

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<sup>35</sup>T.J. Bole III and W.B. Bondeson, *Rights to Health Care*, vol. 38 (Springer, 1991).2

<sup>36</sup>Meier, "Highest Attainable Standard: Advancing a Collective Human Right to Public Health, The."120

<sup>37</sup>Toebe, "Towards an Improved Understanding of the International Human Right to Health." 3

<sup>38</sup>T.K. Hervey, "The "Right to Health" in European Union Law," *HERVEY, TK and KENNER, J., Economic and Social Rights under the EU Charter of Fundamental Rights. A Legal Perspective, Portland, Hart Publishing* (2003). 195

<sup>39</sup>Nnamuchi, "Kleptocracy and Its Many Faces: The Challenges of Justicability of the Right to Health Care in Nigeria."9

<sup>40</sup>Coomans, "Economic, Social and Cultural Rights." 5-12, online at <http://www.uu.nl/uupublish/content/16-2.pdf> accessed 07/11/2012

<sup>41</sup>Vienna Declaration and Programme of Action 1993 see also J. W. Nickel, "Rethinking Indivisibility: Towards a Theory of Supporting Relations between Human Rights," *Human Rights Quarterly* 30, no. 4 (2008).S. P. Marks, "Past and Future of the Separation of Human Rights into Categories, The," *Md. J. Int'l L.* 24(2009). AlsoJ. Sellin, "Justiciability of the Right to Health: Access to Medicines-the South African and Indian Experience," *Erasmus Law Review* 2, no. 4 (2009).452 and F. Coomans, "Economic, Social and Cultural Rights," *SIM Special* 16(1995). 5-6 see alsoM. Scheinin, "Economic and Social Rights as Legal Rights," in *Economic, Social, and Cultural Rights* ((2001)).29

recognizing human rights is pointed out by Kinney who states that “The Vienna Declaration has become a crucial principle in international human rights law recognizing the irreducible truth that all human rights must be recognized if specific human rights are to have concrete meaning.”<sup>42</sup> From the relevant literature, and particularly the contribution of courts, a strong linkage between the right to health and so-called negative rights such as the right to life has been recognised.<sup>43</sup> For instance, the Indian Supreme Court has undertaken its constitutional interpretation of the fundamental right to life in a broad way that has allowed it to include the right to have good health.<sup>44</sup>

There is, it is argued here, therefore no need to divide human rights into two groups or to insist that a particular right must be listed in a particular class. The UDHR, which is considered as the historical basis of human rights, clearly did not perceive this as being necessary, and this was further accepted in the first draft of the 1966 conventions which included all human rights in one agreement without differentiation between civil and political rights and economic and social rights. As Yamin says, “[s]ince the end of the cold war the interdependence and indivisibility of economic, social, and cultural rights and civil and political rights has been broadly accepted.”<sup>45</sup> Thus, it could be said that, in terms of legal status, human rights might be protected and enforced as one set. In reality, however, enforcement of human rights depends on the willingness of states to give all human rights a central position in their national legal systems. For example, implementation of international human rights treaties requires states to take all necessary steps to incorporate them into national law, starting with the ratification of the treaty, translating it into national legislation if needed, and creating and empowering some sort of legal body (courts or other arenas) to monitor how such treaties are implemented at the domestic level.

Therefore, one can observe that there is a gap between talking about human rights (whether political or social) and exercising them in reality. This gap appears clearer in the second generation of human rights, such as any right to health(care), where constructional and linguistic problems are obvious in comparison to the first generation of rights. These problems affect not only the concept and the contents of any right to health but also its nature and the state’s responsibility for its vindication

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<sup>42</sup>Kinney, "International Human Right to Health: What Does This Mean for Our Nation and World." 1462

<sup>43</sup>S.R. Keener and J. Vasquez, "Life Worth Living: Enforcement of the Right to Health through the Right to Life in the Inter-American Court of Human Rights, A," *Colum. Hum. Rts. L. Rev.* 40(2008). 606-615

<sup>44</sup>Shah, "Illuminating the Possible in the Developing World: Guaranteeing the Human Right to Health in India." 462

<sup>45</sup>Yamin, "The Right to Health under International Law and Its Relevance to the United States." 1157

In conclusion of this section, it is worth noting that in the view of human rights advocates there is no need to treat civil and political rights differently from economic and social rights.<sup>46</sup> A unified view of human rights is also appropriate given the termination of the significantly different ideologies between Western and Eastern countries which, as has been explained, many writers believe was behind the separation in the first place.<sup>47</sup> Finally, having a unified view of human rights will resolve a significant problem that they face in terms of the language of the rights themselves that affects their very nature. It is, therefore, important to discuss briefly the nature of human rights.

### 1.3 The Nature of Human Rights

This is a complex issue that has not yet been fully resolved. However, there is agreement that human rights are rights which relate to human beings because they are human, without discrimination based on race, sex, colour, religion or ethnic origin. The nature of human rights has been examined from several perspectives, including philosophical,<sup>48</sup> ethical<sup>49</sup> and legal.<sup>50</sup> This thesis will focus on the nature of human rights in legal terms, but it will take into account other perspectives when this is necessary and relevant.

From a legal perspective, a number of positions on the nature of human rights have emerged. The first view is that human rights, especially economic and social rights, are no more than guidelines that states parties are supposed to take into account in respect of the treatment of their citizens, but that there is no legal duty to do so. Effectively, they are

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<sup>46</sup>This is the position of developing countries, the International Committee on Human rights specifically in its general comments and Academic writers such as Tamara Hervey and Gary Jones

<sup>47</sup>A. Kirkup and T. Evans, "The Myth of Western Opposition to Economic, Social, and Cultural Rights? A Reply to Whelan and Donnelly," *Human Rights Quarterly* 31, no. 1 (2009). 225-237, D. J. Whelan and J. Donnelly, "The West, Economic and Social Rights, and the Global Human Rights Regime: Setting the Record Straight," *Human Rights Quarterly* 29, no. 4 (2007). See also S.L. Kang, "The Unsettled Relationship of Economic and Social Rights and the West: A Response to Whelan and Donnelly," *Human Rights Quarterly* 31, no. 4 (2009). And D. J. Whelan and J. Donnelly, "Yes, a Myth: A Reply to Kirkup and Evans," *Human Rights Quarterly* 31, no. 1 (2009). I. E. Koch, *Human Rights as Indivisible Rights: The Protection of Socio-Economic Demands under the European Convention on Human Rights* (Martinus Nijhoff, 2009). 6 also E. Wiles, "Aspirational Principles or Enforceable Rights-the Future for Socio-Economic Rights in National Law," *American University International Law Review* 22(2006). and S. P. Marks, "The Past and Future of the Separation of Human Rights into Categories," *MD. J. INT'L L.* 24(2009). And also, J. K. Mapulanga-Hulston, "Examining the Justiciability of Economic, Social and Cultural Rights," *The International Journal of Human Rights* 6, no. 4 (2002).

<sup>48</sup>See J.J. Shestack, "The Philosophic Foundations of Human Rights," *Human Rights Quarterly* 20, no. 2 (1998). 201-234 see also M. Freeman, "Philosophical Foundations of Human Rights," *Human Rights Quarterly* 16(1994).491-514

<sup>49</sup>M. A. Freeman, *Human Rights: An Interdisciplinary Approach* (Key Concepts, 2011). 6-31, E. Riedle, "The Human Right to Health: Conceptual Foundations," *Realizing the Right to Health. Zurich: Rüffer and Rub* (2009).

<sup>50</sup>J. Donnelly, *International Human Rights* (Westview Press Boulder, CO, 1993).

aspirational in terms of improving the relationship between the state and its citizens.<sup>51</sup> Thus, the state can choose how to deal with its population with no obligation to do so in a particular way. From this standpoint, human rights are merely guidelines designed to encourage countries to take into account certain rights in formulating their policies. In a practical sense, there is, however, little to support this view, since the international community - including states themselves<sup>52</sup>- has taken significant steps towards the recognition of human rights.<sup>53</sup> In fact, states are required to respect human rights in both internal and external matters in terms of the UN Charter.<sup>54</sup>

The second point of view is based on the position that human rights law is really just the recognition of certain ethical standards, and that their translation into legally binding instruments is dependent on the willingness of states to do so. Because these rules are soft law, the state can refuse to implement its commitments under them at any time and for any reason.<sup>55</sup> For example, states can refuse to enforce their human rights obligations because of a lack of available resources; this can restrict them in the execution of their obligations. Although this perspective acknowledges that human rights are legal rights, it considers them as an obligation of conduct more than an obligation of outcome and this is particularly the case in terms of economic and social rights.<sup>56</sup> Although this view of human rights can be criticized because of its ambiguity, it also appears to support the division of human rights into civil and political rights and socioeconomic rights which has already been criticised on many occasions such as in the Vienna Declaration 1993<sup>57</sup> and in general

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<sup>51</sup>S. Marks, "Human Right to Development: Between Rhetoric and Reality, The," *Harv. Hum. Rts. J.* 17(2004). 147, T. Goodman, "Is There a Right to Health?," *Journal of Medicine and Philosophy* 30, no. 6 (2005). 652

<sup>52</sup>Most countries have specified human rights norms in their constitutions or at least they enacted a special legislation for human rights.as pointed out by Soohoo and Goldberg 187 countries contain right to health in their constitutions. C. Soohoo and J. Goldberg, "Full Realization of Our Rights: The Right to Health in State Constitutions, The," *Case W. Res. L. Rev.* 60(2009). 1004

<sup>53</sup>For instance, most states have signed and ratified the main human rights treaties such as the International Covenant on Civil and Political Rights and International Covenant on Economic, Social and Cultural Rights, they have also given these rights a legal value in their constitutional law. States shown respect of human rights by establishing an independent human rights institution or even a ministry of human rights which usually associated with human rights law.

<sup>54</sup>In its article (1) para 3 available online at <http://www.un.org/aboutun/charter/index.html>

<sup>55</sup>P. Alston and J. Crawford, *The Future of Un Human Rights Treaty Monitoring* (Cambridge Univ Pr, 2000).201, also D. P. L. Chong, "Five Challenges to Legalizing Economic and Social Rights," *Human Rights Review* 10, no. 2 (2009).192 when he comments about the USA attitude in regard to the socioeconomic rights.

<sup>56</sup>Dennis and Stewart, "Justiciability of Economic, Social, and Cultural Rights: Should There Be an International Complaints Mechanism to Adjudicate the Rights to Food, Water, Housing, and Health?." 470

<sup>57</sup>Paragraph 5 of Vienna Declaration and Programme of Action 1993 available on line at <http://www2.ohchr.org/english/law/pdf/vienna.pdf> accessed 25/09/2012

comment 14.<sup>58</sup> In addition, one can say that this view is no longer widely accepted; indeed, now most international law documents state that, in the case of conflict between the human rights obligations and other obligations of the state, whether national or international, the state has a duty to take into account human rights obligations. Thus, states are required to act in conformity with the purposes and principles of human rights conventions.<sup>59</sup>

The third viewpoint is that human rights are a part of customary international law<sup>60</sup> and are therefore legal rules binding on States, particularly those whose actions contributed to creating them.<sup>61</sup> In other words, the rules of human rights are binding on states as customary international law because they are produced by states' practice. Logically, it seems that this view is preferable. In this context, it is important to pay attention to the view of Jin-Xue Fan who states that "[u]nlike legal rights, human rights exist whether or not the government recognised them. They are binding against government and the state".<sup>62</sup>

Above all, human rights are still the subject of debate, so no one can be sure about their nature. Thus, human rights have been influenced by different disciplines such as ethics, philosophy and law. Therefore all of these disciplines have something to say about human rights and all of them are relevant in discussing the nature of human rights: the nature of human rights cannot be discovered from merely one perspective. Whatever theoretical account is accepted, there is nonetheless agreement that human rights belong to all human beings because they are human; the purpose of these rights is to protect individuals from certain kinds of state action. Thus, human rights are best understood as commitments by, and restrictions on, the state.<sup>63</sup>

It is clear that human rights are significant for both states and individuals, at national and international levels, in the economic, social and political arena, and as part of philosophical, moral and legal aspirations. Cassel, for example, states that "the fundamental idea of the social contract is that persons come together in a society and give up some liberty rights and some private property (as is the case when we pay taxes) in

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<sup>58</sup> United Nations, Office of the High Commissioner for Human Rights, General Comment No 14 available at <http://www.unhcr.org/refworld/pdfid/4538838d0.pdf>, accessed on 28/09/2012

<sup>59</sup> Ian. Brownlie, *Principles of Public International Law*, ed. Sixth (Oxford University press, 2003). 537

<sup>60</sup> Ibid.537

<sup>61</sup> Riedle, "The Human Right to Health: Conceptual Foundations." 22

<sup>62</sup> J.X. Fan, "On the Two Sides of Human Rights," *Int'l Legal Theory* 9(2003). 81

<sup>63</sup> Ibid. 85 see also Vojin Dimitrijevic, "Customary Law as an Instrument for the Protection of Human Rights," ISPI Istituto per gli Studi di Politica Internazionale, [http://www.ispionline.it/it/documents/wp\\_7\\_2006.pdf](http://www.ispionline.it/it/documents/wp_7_2006.pdf). accessed on 28/03/2008

order to allow the state to do for people some things that they cannot do as well for themselves.”<sup>64</sup> In the context of international law, human rights, as has been pointed out in many cases <sup>65</sup> should be taken into account in assessing the behaviour of all states. Thus, article 2 of the ICCPR, as well as the ICESCR, emphasises that states should cooperate individually and collectively for the realisation of human rights, irrespective of the position of those who support the separation of human rights into two groups.

In terms of the nature of human rights, it might be necessary to make a differentiation between international human rights agreements, supporters of human rights and the national mechanisms of human rights. In light of international human rights agreements, human rights are not equal. Therefore, first generation rights are real and enforceable - and more importantly perhaps justiciable - whereas second generation rights, which would include any right to health, are ambiguous, vague and wide and therefore not justiciable. On the third account, it would not be possible to recognise a right to health an individual human right.<sup>66</sup>

From the perspective of human rights supporters, as already explained, human rights are equal whether that right is first, second even third generation. However, given the existing categorisation of human rights, it would seem that some human rights (but for the moment not others) are considered real, full and universal by governments,<sup>67</sup> requiring that states respect them and take all necessary steps not only to protect them but also to fulfil them, Otherwise citizens have the right to challenge the state to ensure compliance.

## **1.4 The Position of the Right to Health in Sets of Human Rights**

The claim that health is a human right generated debate concerning its definition, classification and implementation. To understand these debates, an attempt is made to explain the position of health in relation to the two categories of human rights. Thus, it will

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<sup>64</sup>C. Cassel, "Right to Health Care, the Social Contract, and Health Reform in the United States," *Louis ULJ* 39(1994).56

<sup>65</sup>such as *Reservations to the Convention on the Prevention and Punishment of the Crime of Genocide, Legal Consequences for States of the Continued Presence of South Africa in Namibia, South-West Africa Cases (Ethiopia v. South Africa; Liberia v. South Africa, ase Concerning the Barcelona Traction, Light and Power Company Limited, Case Concerning United States Diplomatic and Consular Staff in Tehran,an Case Concerning Military and Paramilitary Activities in and against Nicaragua,*

<sup>66</sup>Goodman, "Is There a Right to Health?." 652-53

<sup>67</sup>Eide and Rosas, "Economic, Social and Cultural Rights: A Universal Challenge."17

be possible to investigate three main points: the importance of health, the problems of the right to health in relation to the language of rights and their definition, and how implementation of any right to health could be achieved in reality. Therefore, the distinction between positive and negative rights needs to be explained further in this subsection. For these purposes, and despite the caveats outlined above about its true status, the language of a 'right to health' will be used as a means of exploring what its meaning and content might be.

At first sight one might say that health as a human right would appropriately be viewed as a positive right. Gewirth defines positive rights by saying that "positive rights entail positive duties, i.e., duties to help persons to have the objects of their rights."<sup>68</sup> From this perspective, the right to health would at a minimum require that appropriate health services were available when needed.<sup>69</sup> However, human rights jurisprudence would seem to indicate that health has been treated both as a negative right and as a positive one. The European Court of Human Rights, for instance, has considered the right to health as part of the right to life encompassed in the ICCPR.<sup>70</sup> Similarly, the Inter-American Court has dealt with the right to health care.<sup>71</sup>

In this study, the focus will be on the position of health care rather than on the different views between the Western and Eastern countries which can, as already indicated, be traced to ideological perspectives.<sup>72</sup> Thus, the central position of health care can be seen by the change in American health policy which adopted by Obama administration in 2010 when he introduced the Patient Protection and Affordable Care Act to guarantee health care services to all Americans. As explained by Steinbrook, "The law's goals include increasing the number of people who are covered by health insurance, slowing the rate of increase in medical costs, and overhauling many facets of healthcare"<sup>73</sup>. On June 28 2012, the USA Supreme Court examined the constitutionality of the Affordable Care Act and gave a green

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<sup>68</sup>Gewirth, "Are All Rights Positives? ." 322

<sup>69</sup>See *infra*. Chapter

<sup>70</sup>This can be seen in the judgment of the European Court of Human rights when it dealt with health as human right. for example see these cases D v United Kingdom

<sup>71</sup>See Monica Feria Tinta, "Justiciability of Economic, Social, and Cultural Rights in the Inter-American System of Protection of Human Rights: Beyond Traditional Paradigms and Notions," *Human Rights Quarterly* 29, no. 2 (2007).

<sup>72</sup>Gewirth, "Are All Rights Positives? ." 322, Whelan and Donnelly, "The West, Economic and Social Rights, and the Global Human Rights Regime: Setting the Record Straight." 910

<sup>73</sup>R. Steinbrook, "The Us Supreme Court's Ruling on the Patient Protection and Affordable Care Act," *BMJ: British Medical Journal* 344(2012). 1

light to the plan to continue.<sup>74</sup> This is a huge victory for the advocates of a right to health care in both USA and the world. Such a change in the American perspective might result in a U-turn in how other governments deal with health (care) in the future. The American example also shows that even if health is still not considered as a real human right it was and remains a fundamental political, economic and legal issue in every country. Indeed, in many Western countries health has been afforded a level of protection irrespective of whether this was under a human rights law, ordinary law or only moral 'law'.

In the USA, for instance, commentators had made strong criticism of the attitude of previous governments which rejected subsidisation of health care services. In her comment on American health policy, Pereira argues that American citizens have been misled as to the relative standing of civil and political rights and socioeconomic rights, such as the right to housing, health care, food, and education.<sup>75</sup> She contends that "the government [the USA government] denies individuals basic access to healthcare due to economic reasons."<sup>76</sup> In other words, the roots of the distinction between the two sets of rights in practice are pragmatic rather than ideological. And she asks - pointing to a perverse outcome of the separation of rights into specific categories - how can prisoners have a right to health care when law abiding citizens do not enjoy such a right?<sup>77</sup>

Clearly, health is important to ensure the enjoyment of political and civil rights. Thus, it appears logical that to ensure the equal political participation of all citizens; the state is required not only to refrain from certain harmful actions but also to create a proper political environment that encourages the development of active, engaged, autonomous citizens.<sup>78</sup> Moreover, the discussion about the cost of social rights is no longer valid, as studies show that implementation of political and civil rights is more expensive in most cases than positive rights.<sup>79</sup>

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<sup>74</sup> Supreme Court of the United States, *National Federation of Independent Business et al v Sebelius, Secretary of Health and Human Services, et al*, <http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf> accessed 06/09/2012

<sup>75</sup> PEREIRA, "Live and Let Live: Healthcare Is a Fundamental Human Right." 421-422

<sup>76</sup> *ibid.* 422

<sup>77</sup> *ibid.* 425

<sup>78</sup> J. Donnelly, "The Social Construction of Human Rights," in *Human Rights in Global Politics*., ed. T. Dunne, and N.J. Wheeler (Cambridge University Press 1999). 87

<sup>79</sup> Holmes and Sunstein, *The Cost of Rights: Why Liberty Depends on Taxes*.223, L. Forman, "What Future for the Minimum Core? Contextualizing the Implications of South African Socioeconomic Rights Jurisprudence for the International Human Right to Health," (2011). 63

A different position seems to be adopted in Europe, where the European Court of Human Rights has considered the right to health as part of the right to life, while the European Social Charter has dealt with these issues independently.<sup>80</sup> Tamara Hervey, a European writer, states that "...the realisation that, in practice, civil and political rights may be rendered meaningless without the means to enjoy them has led some to argue that social rights are *higher* in value than civil and political rights".<sup>81</sup> Hervey argues that rights, such as the right to health, are as important as the right to life and should be equally and legally protected and recognised independently.

For some, then, health should be seen as a fully independent right, recalling Meier's comments about the relationship between human flourishing and the importance of health, which were referred to *supra*..<sup>82</sup> The idea that other rights cannot be fully implemented until the right to health is respected has also been affirmed by Toebes.<sup>83</sup> Most importantly, this view has been supported in several cases by decisions of the Inter- American Court.<sup>84</sup>

However, at present the right to health (however described) is listed in the category of positive rights, which can be described as 'obligations of conduct' rather than 'obligations of result'.<sup>85</sup> The International Committee on Economic, Social and Cultural Rights in its comment no (3) states that "Article 2 is of particular importance to a full understanding of the Covenant and must be seen as having a dynamic relationship with all of the other provisions of the Covenant. It describes the nature of the general legal obligations undertaken by States parties to the Covenant. Those obligations include both what may be termed (following the work of the International Law Commission) obligations of conduct and obligations of result."<sup>86</sup> Dias points out that "[t]he obligations of conduct require action reasonably calculated to realize the enjoyment of a particular right."<sup>87</sup> On the other hand, he argues that 'obligations of result' require States to guarantee that the steps they have taken and the measures they have adopted are able to generate the desired outcome and accomplish specific targets to satisfy a detailed substantive standard. For this reason,

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<sup>80</sup>Article 11 and 13 of the European Social Charter however it is not binding agreement.

<sup>81</sup>Hervey, "The "Right to Health" in European Union Law." 195

<sup>82</sup>Meier, "Highest Attainable Standard: Advancing a Collective Human Right to Public Health, The." 120

<sup>83</sup>Toebes, "Towards an Improved Understanding of the International Human Right to Health." 3

<sup>84</sup> See Tinta, "Justiciability of Economic, Social, and Cultural Rights in the Inter-American System of Protection of Human Rights: Beyond Traditional Paradigms and Notions."

<sup>85</sup>General Comment No 14

<sup>86</sup>CESCR, General Comment 3, para. 10.

<sup>87</sup>Clarence J. Dias. Towards effective monitoring compliance with obligations and progressive realization of ESCR. Available at [http://hdr.undp.org/docs/publications/background\\_papers/Dias2000.pdf](http://hdr.undp.org/docs/publications/background_papers/Dias2000.pdf) accessed 07/11/2012

and the other reasons outlined above, it should be clear that proper recognition of the right to health could and should impose legal obligations on states parties, regardless of the availability of resources. In other words, categorising health as merely a socioeconomic right neither recognises its fundamental importance nor accords it an appropriate status.

## **1.5 Evaluation of Recent Expressions of the Right to Health**

In general, it seems that international organisations, as noted by Bilder, “have tended to label too many aspirations as “human rights” and that this proliferation may diminish the concept of human rights as a claim of individual freedom and dignity against the authority of the state.”<sup>88</sup> This may be true in terms of the tendency to adopt wider and different concepts of rights, but it does not undermine the importance of international organisations continuing to take human rights seriously.

Equally important is the ability to identify the core of the right in question, as without this it is difficult both to measure outcomes and to challenge failure. In the case of the right to health, as will be argued, the language in which efforts to describe it has been couched has added to the problems confronting its recognition and vindication. It seems self-evident that to be able effectively to claim something as a human right, it is necessary that it be clearly defined so that citizens, courts and other institutions can explain what is meant by it. Without a clear conception of the meaning of any right to health it is unlikely that it will prove to be of value to those seeking to enforce or claim it. Additionally, a clear conceptualisation of a right to health will help the relevant actors to understand and apply its benefits in both theoretical and practical ways. It is, therefore, important to highlight why the confusion surrounding efforts to describe such a right has occurred, before considering the meaning of each of the expressions used to describe it, and the negative impact that these have had on efforts to make progress in this area. To understand the concept of a right to health, there is a need to discuss its legal basis, which is an important means of encouraging states to recognise that the right is not only a ‘gift’ from the government but also a legal obligation upon states. This legal obligation rests on international treaties which states have accepted and are therefore obliged to comply with. Such legal obligations require the state to make and implement health regulation and policy. What follows is a discussion of the various ways in which these obligations have been conceptualised.

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<sup>88</sup>Bilder, "An Overview of International Human Rights Law." 15

## 1.5.1 The Right to Medical Care

Medical care can be described in this way:

Care of sickness or injury under the direction of a physician or, more loosely, care provided by any qualified professional person in a health-related institution, clinic, or comparable setting.<sup>89</sup>

This statement focuses on the provision of the curative (or palliative) services that may be needed by citizens. Medical care is, of course, an essential part of any right to health. This language – a right to medical care - is mostly found in the human rights literature of the USA, where economic and social rights are not yet generally recognized by the state.<sup>90</sup> In the American understanding of rights in this area health is a personal issue, and as it is, it should be left to the market and the ability of everyone to pay and choose. Thus, it appears that health care in America has been linked to curative programs rather than those which are preventive. Advocates of this interpretation of the right to health focus on the right to medical care, rejecting a more broadly defined right to health that includes other important issues, for example those related to the prevention of illness.<sup>91</sup>

This narrow definition was designed to provide universal access to medical care, but it did not take adequate account of the other determinants of health and well-being. In conclusion, the right to medical care would be an important part of a right to health but it is insufficiently broad to encompass what was intended by international declarations. It is important to note that the right to health as described in the WHO constitution<sup>92</sup> and other international agreements, including the ICESCR, aims not only to guarantee medical services to persons who are already sick but also to prevent them from becoming ill in the first place. Prevention and control of diseases requires more than providing medicine or drugs and takes in a wide range of public policy issues.

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<sup>89</sup>Oxford reference online premium. Available at [http://www.oxfordreference.com/views/SEARCH\\_RESULTS.html?go.x=22&over=Full\\_Text&qt=boole an&q=medical%20care&category=s1&category=s16&category=s2&category=s3&category=s4&category=s5&category=s6&category=s28&category=s7&category=s8&category=s9&category=s11&category=s12&category=s13&category=s25&category=s14&category=s15&category=s17&category=s24&category=s29&category=s18&category=s19&category=s20&category=s30&category=s21&category=s22&category=s23&go.y=9&ssid=959589199&scope=global&time=0.37337170484161](http://www.oxfordreference.com/views/SEARCH_RESULTS.html?go.x=22&over=Full_Text&qt=boole an&q=medical%20care&category=s1&category=s16&category=s2&category=s3&category=s4&category=s5&category=s6&category=s28&category=s7&category=s8&category=s9&category=s11&category=s12&category=s13&category=s25&category=s14&category=s15&category=s17&category=s24&category=s29&category=s18&category=s19&category=s20&category=s30&category=s21&category=s22&category=s23&go.y=9&ssid=959589199&scope=global&time=0.37337170484161) accessed 23/02/2009

<sup>90</sup>S. D. Jamar, "International Human Right to Health," *Sul rev.* 22(1994).5

<sup>91</sup>Hernán Luis Fuenzalida-Puelma and Susan Scholle Connor, "The Right to Health in the Americas: A Comparative Constitutional Study," *Pan American Health Organization* (1989).

<sup>92</sup>Health World Organisation, WHO Constitution, available on line at <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf> accessed 31/08/2012

Using the terminology of a right to medical care will cause several problems. First of all, it will limit the right to health as a socioeconomic right. Further, it will increase the cost of health provision, as treatment programs tend to be more expensive than preventive programs. Thus, limiting the right to health to the mere provision of medical care can be rejected.<sup>93</sup>

### **1.5.2 The Right to Health Protection**

The right to health is interpreted by some writers<sup>94</sup> and some constitutions and international treaties, such as the African Charter on Human and Peoples` Rights,<sup>95</sup> as equivalent to a right to health protection. However, this is not a position adopted by all commentators. The disagreement about the importance of a right to health protection begins with the meaning of the phrase itself.

According to Toebes, 'protection' does not necessarily need to be explicit in phrases that are used for human rights: In the language of human rights, 'protection' is an underlying concept whenever the right is mentioned.<sup>96</sup> The point is that the existence of a legal right assumes legal protection, making it redundant to use the word 'protection'. In addition, it has been argued that the term 'protection' is one of the positive obligations inferred from social rights. Under these positive obligations, the state is required to undertake the necessary steps for implementing socio-economic rights. In this context, the positive obligations comprise three types of action; to respect, to protect, and to fulfil.<sup>97</sup>

Toebes also states that the right to health protection is in any case a confusing phrase which will not cover all of the content and meaning of a right to health.<sup>98</sup> On this analysis, the term 'protection' both expands the scope of the right to health and allows other related rights to be included, resulting in problems in achieving the right to health itself.

Finally, it could be argued that using the term 'protection' is an historical rather than a legal device. Human rights history has assumed that there are two parties - the state and the individual - and that the former has the power and the authority over the latter. The latter

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<sup>93</sup>Jamar, "International Human Right to Health."35

<sup>94</sup>See the position of the editors of right to health in Americans who prefer to use the term 'right to health protection' H.L. Fuenzalida and S. Scholle-Connor, "The Right to Health in the Americas: A Comparative Constitutional Study," *Pan American Health Organization* (1989).599

<sup>95</sup>Article 16

<sup>96</sup>Toebes, *The Right to Health as a Human Right in International Law*.

<sup>97</sup>Ibid. 306-38, B. Toebes, "The Right to Health," *Economic, social and cultural rights* (2001). 179-80

<sup>98</sup>Toebes, *The Right to Health as a Human Right in International Law*. 20

has tried to limit that power by couching claims in terms of human rights. As a result, the term 'protection' has been used in both national and international human rights documents in order to balance the relationship between citizens and the state. Therefore, human rights documents have sought to make clear that human rights include the right to protection.

For example, the term 'protection' has been used in the European Social Charter, the Convention on the Elimination of All Forms of Discrimination against Women, and the African Charter on Human and Peoples` Rights (AfCHR), which states in article 16, that "1. Every individual shall have the right to enjoy the best attainable state of physical and mental health. 2- States parties to the present charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick".<sup>99</sup>In short, to take the right to health as the 'right to health protection' means that the right remains a political rather than a legal issue. Yet to be of real value, the right needs to be enforceable.

### **1.5.3 Right to Health**

It was explained earlier that, before a refined definition of the right in question was offered, the language of a 'right to health' would be used. However, this is not to say that this terminology is preferred. A significant number of scholars have pointed out that a right to health is unachievable since no right can guarantee everyone health.<sup>100</sup> On the other hand, writers such as Toebes prefer to use the phrase 'the right to health' as the appropriate expression in terms of legal discourse.<sup>101</sup> Proponents, who support this view, have offered a number of arguments to support their position. The first and most important is that the right to health is the phrase most commonly used in international human rights conventions.<sup>102</sup> Second, they argue that even if health cannot be guaranteed, using the term 'the right to health' will at least emphasise the right to the highest possible standard of health.

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<sup>99</sup>The African Union.African Charter on Human and Peoples` Rights. 1981. entered into force in 1986 <http://www.africa-union.org/root/au/Documents/Treaties/Text/Banjul%20Charter.pdf> accessed 05/11/2012

<sup>100</sup>Fuenzalida and Scholle-Connor, "The Right to Health in the Americas: A Comparative Constitutional Study." 597

<sup>101</sup>Toebes, *The Right to Health as a Human Right in International Law*.

<sup>102</sup>V. A. Leary, "The Right to Health in International Human Rights Law," *Health and Human Rights* 1, no. 1 (1995).

However, the fundamental problem of referring to a ‘right to health’ is that the breadth of the concept causes difficulty in implementing it in reality.<sup>103</sup> According to the editors of *The Right to Health in the Americas* the right to health is unachievable because it is too broad.<sup>104</sup> To be effective, as Buchanan argues, the concept needs to be refined and limited.<sup>105</sup> But this limitation does not mean that a right to health must be shrunk to the level where it does not meet human beings’ needs and patients’ expectations. In other words, neither the broader concept of the right to health, as in the international trend, nor the narrower concept, that limits it to only medical care or emergency care, is acceptable; in fact we need a definition that meets our needs and which it is possible to achieve. In the view of Buchanan, adopting one of these definitions without balance would result in meaningless notion and make the problem more complicated instead of resolving it.<sup>106</sup> Sprumont has also noted the importance of recognising a minimum content for the right, arguing that if the content of the right is unlimited, the government’s health obligations will be more political than legal.<sup>107</sup> Therefore, the right must be restricted to some degree, allowing us to ensure that it becomes possible to vindicate it. To be useful to the intended beneficiaries, its content must be clearly determined; if it is too broad, it will be legally meaningless.

The fact that the ‘right to health’ is a common phrase in international human rights is not in any case a sufficient justification for accepting it as the best definition. Human rights are important concepts which regulate and define the relationship between states and individuals. With this in mind, the language used to describe the right must be clear and readily interpretable in order that each party understands its obligations and rights. As Asher points out, human rights are claim rights and this supposes that the rights of one party impose a corresponding duty on another to implement them.<sup>108</sup> In this context, Martha Nussbaum makes the important point that “people are more comfortable talking

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<sup>103</sup>J. Ruger, "Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements," *Yale Journal of Law & the Humanities* 18(2006). 312

<sup>104</sup>Fuenzalida and Scholle-Connor, "The Right to Health in the Americas: A Comparative Constitutional Study." 597

<sup>105</sup>A. E. Buchanan, "The Right to a Decent Minimum of Health Care," *Philosophy & Public Affairs* 13, no. 1 (1984). 55-56

<sup>106</sup>*Ibid.* 55-56

<sup>107</sup>D. Sprumont, "Unwritten Constitutional Right to Subsistence Brief Comment of 27 October 1995 Judgment of the Swiss Federal Court in the Perspective of a Right to Health Care," *European Journal of Health Law* 5(1998).414

<sup>108</sup>J. P. Asher et al., *The Right to Health: A Resource Manual for Ngos* (Commonwealth Medical Trust, 2004). 7

about the right to health care than the right to health, for health is something that lies outside our control".<sup>109</sup> This will be returned to *infra*.

In any case, there is no evidence that the right to health is a term commonly used in international human rights documents. In fact, international human rights documents generally use another phrase - the "right to the highest attainable standard of health". This will be discussed later. The WHO describes health as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity".<sup>110</sup> In spite of the ostensible value of this definition it has been widely criticized. First, this definition is wide and needs to be narrowed.<sup>111</sup> For example, Sparerl has suggested that it may be better if health is defined as a state in which the person is free from disease or pain instead of complete physical, mental health and well-being.<sup>112</sup> Accepting the WHO definition, in the opinion of other writers, would mean that health services would have to be involved in all areas of human activity.<sup>113</sup> In addition, Bok has stressed that the WHO definition of health must be seen as no more than an historical document and that it should be respected as such. In operational terms, she believes that the WHO definition of health is impractical.<sup>114</sup> Second, the WHO definition of health includes unnecessary terms which, in fact, make it a more problematic concept; this has had a negative impact on the meaning of the right to health in international conventions.<sup>115</sup>

In short, the term 'the right to health' does not facilitate the goals of international conventions as it is unattainable at worst and vague at best. This has been noted by the Pan American Health Organization (hereafter PAHO). In its valuable study on the right to health, PAHO emphasised that the use of the phrase 'right to health' may be both inadequate and conceptually confusing.<sup>116</sup> Thus, it seems necessary, at least in terms of

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<sup>109</sup>Economic and social rights and the right to health. Harvard law school. 1993. 34

<sup>110</sup> WHO- WHO constitution 1948, online at [http://www.who.int/governance/eb/who\\_constitution\\_en.pdf](http://www.who.int/governance/eb/who_constitution_en.pdf) accessed 06/11/2012

<sup>111</sup>Ruger, "Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements." 312

<sup>112</sup>E. V. Sparer, "The Legal Right to Health Care: Public Policy and Equal Access," *Hastings Center Report* (1976). 39

<sup>113</sup>T.C. de Campos, "Health as a Basic Human Need: Would This Be Enough?," *The Journal of Law, Medicine & Ethics* 40, no. 2 (2012).252-53, Toebes, *The Right to Health as a Human Right in International Law*. 23.

<sup>114</sup>S. Bok, "Rethinking the Who Definition of Health," *Harvard Center for Population and Development Studies, Working Paper Series* 14, no. 7 (2004).14

<sup>115</sup>Jamar, "International Human Right to Health." 54

<sup>116</sup>Fuenzalida and Scholle-Connor, "The Right to Health in the Americas: A Comparative Constitutional Study." 13

human rights, to look for an adequate term or definition that meets the requirements of both linguistic and legal concerns.

#### 1.5.4 The Right to the Highest Attainable Standard of Health

In reviewing the international literature on health as a human right an alternative phrase – the right to the highest attainable standard of health - is often used to articulate the meaning of the right to health. In fact, this is the most commonly used phrase in international documents. For example, in 1966, the International Commission on Economic, Social and Cultural Rights (hereafter ICESCR)<sup>117</sup> used this expression in article 12 which states 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...”<sup>118</sup>

This phrase suffers from similar problems to those above: excessive broadness, ambiguity and uncertainty. Despite these weaknesses, this phrase has been used by the ICESCR<sup>119</sup> and in many international documents.<sup>120</sup> This is perhaps indicative of why there are difficulties in the understanding of the right to health: it crosses national and international boundaries and for this reason may suffer from a lack of precision. A general problem, which it shares with the other definitions already discussed, is the difficulty of identifying precisely what it means. In his report, Lie criticizes the use of this terminology which, according to him, fails to specify what it means<sup>121</sup> and how states can provide or guarantee it. Any right in this area requires a clear baseline which can be used to evaluate the health services that are provided by the state.<sup>122</sup>

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<sup>117</sup> Emilia Sternberg, Right to health in K. Bachenberg et al., "Show Me the Money: Achieving Economic, Social, and Cultural Rights through Government Budgets," (2011). 81 available at <https://dlib.lib.washington.edu/dspace/bitstream/handle/1773/16494/Task%20Force%20M%202011.pdf?sequence=1> accessed 20/01/2012

<sup>118</sup>International Covenant on Economic, Social and Cultural Rights. Available at <http://www2.ohchr.org/english/law/pdf/cescr.pdf> accessed 20/08/2009

<sup>119</sup>Emilia Sternberg, Right to health in K. Bachenberg et al., "Show Me the Money: Achieving Economic, Social, and Cultural Rights through Government Budgets," (2011). 81

<sup>120</sup> For example see Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights "Protocol of San Salvador" 1988 and African charter on human and peoples' rights 1981

<sup>121</sup>R. K. Lie, "Human Rights, Equity and Health Sector Reform," *Unpublished Report*, available at <http://www.ethica.uib.no/rights22.pdf>. (Accessed March 29, 2008.) (2000). 6

<sup>122</sup>A. WEALE, "Between the Highest and the Attainable? Reflections on the Right to Health," *Essex Human Rights Review* 5, no. 1 (2008).

Second, the analysis of the Special Rapporteur, Paul Hunt, arguably made the concept of the right to health more complex.<sup>123</sup> He did not focus on the main problem of the right of everyone to the enjoyment of the highest attainable standard of health. Rather, he discussed and explored other issues such as poverty, rape and health systems. In his 2003 report to the International Commission of Human Rights,<sup>124</sup> Hunt explained his views on health as a human right. He addressed some causes of damage to health, such as poverty and rape of women. While these issues are important, addressing them before resolving the content of the right itself leads to further confusion. In this sense, it is important to take into account Buchanan's assertion that "ensuring a decent minimum of health care for all is more important than projects".<sup>125</sup>

For example, health problems are surely one of the effects of poverty, but implementation of the right to health does not require ending the poverty in the world, although ending or at least reducing poverty would increase the capacity for improving the health situation. In his report, although he clarifies the importance of the right to health, Hunt fails to show or explain what a right to health means or should mean.<sup>126</sup> What Hunt also fails to do is to draw a distinction between a right to health and its causes and effects. However, one major advantage of Hunt's work is that he succeeds in highlighting the legal basis of the right to health by listing domestic and international legal sources. Legal sources will, of course, play a crucial role in the recognition of health as a human right, however it is ultimately defined.

In short, it seems that, despite its acknowledging that the concept of the right to health requires clarification, the international community continues to use the expression that is the original cause of the problem. However, some writers, for example, Toebes<sup>127</sup>, believe that there is no other expression that could be used and that we should, therefore, continue to use the existing terminology. One question that needs to be asked, however, is why we should use a phrase that does not assist us to understand what a right to health means or at least answer how it could be achieved? To date, it seems that this question remains without an answer because of adherence to the formal language of international documents.

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<sup>123</sup>P. Hunt, "The Un Special Rapporteur on the Right to Health: Key Objectives, Themes, and Interventions," *Health and Human Rights* (2003).

<sup>124</sup>Paul Hunt, "Special Rapporteur Report to the International Committee on Human Rights," <http://daccessdds.un.org/doc/UNDOC/GEN/G03/109/79/PDF/G0310979.pdf?OpenElement>.

<sup>125</sup>Buchanan, "The Right to a Decent Minimum of Health Care." 71

<sup>126</sup>Paul Hunt. 2003. The right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Report to Commission on Human Rights. E/CN.4/2003/58. 13 February 2003. 44-58

<sup>127</sup>Toebes, *The Right to Health as a Human Right in International Law*.20

## 1.6 The Main Problem of the ‘Right to Health’

### “The language of rights”

It is clear that confusion surrounds what is meant by a right to health. None of the phrases currently used, and described above, identify its content in a manner that would make it enforceable. As currently described, the right is vulnerable to economic, political, cultural, ideological, legal and linguistic problems.<sup>128</sup>

Although the economic, cultural, ideological and legal problems might be resolved relatively easily, language will remain a main problem. In fact, one can say that most of the other problems are a result of the language that was used in drafting and adopting this right by the international community at that time. A review of academic writings on human rights, and particularly socioeconomic rights, shows that a large number of writers have observed that language has caused considerable confusion surrounding the right to health since the adoption of the ICESCR in 1966.<sup>129</sup> This problem has been identified by Agish. When commenting on the health care system in the USA, he criticised the founders of the Medicare and Medicaid programs in the USA for their failure to realise the importance of health for the whole of society and not only the beneficiaries of these systems.<sup>130</sup>

In legal systems, language plays a fundamental role in identifying the level of obligations that states have. In fact, the language used can explicate the legal basis for the right and also whether it is a real or rhetorical right. In other words, it is argued here that the legitimacy of a given right usually depends on the language that is used to formulate it, so if we are to avoid any confusion in the future we have to articulate human rights provisions in clear words. The existence of any human right is based initially on the international convention or domestic law that produced it, but it is also recognized that the language of rights in these instruments should be precise so as to ensure efficacy and the possibility of justiciability.<sup>131</sup> It is important to ensure that high quality language is used to create and define human rights in order that the core of the right can be identified. This

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<sup>128</sup> Thomas Buergenthal has mentioned effects of these factors not only on the achievement of this goal but it affected also the compliance which becomes much more difficult. See his article: International human rights law and institutions. In Fuenzalida and Scholle-Connor, "The Right to Health in the Americas: A Comparative Constitutional Study." 13

<sup>129</sup>Tinta, "Justiciability of Economic, Social, and Cultural Rights in the Inter-American System of Protection of Human Rights: Beyond Traditional Paradigms and Notions." 434

<sup>130</sup> George J. Agish, 189-190

<sup>131</sup>Tinta, "Justiciability of Economic, Social, and Cultural Rights in the Inter-American System of Protection of Human Rights: Beyond Traditional Paradigms and Notions." 434

core, as Orucu argues, enables the establishment of criteria to evaluate whether the right is vindicated or not.<sup>132</sup> She further stressed that the core of the right will be the minimal level of protection afforded by it and which cannot be breached by anyone.<sup>133</sup>

There are several reasons that might illustrate why the confusion surrounding the right to health has arisen. First, the existence of a right itself has been contentious, especially in the negotiations of the three basic agreements which concern it; namely, the UDHR, the constitution of the WHO, and the ICESCR. In these three agreements, states delegates and international organisations' representatives had different views as to what should be encapsulated in a right to health. Second, the right to health is connected to other human rights, which makes it more difficult to implement. In addition, states have not always recognized health as a human right.<sup>134</sup> With this in mind, each state tried to deal with the right to health using its own interpretations and in line with its own aspirations. Thus, some states adopted a wide interpretation of the right to health while others adopted a more narrow conception, which concentrated on the right to medical care. In short, disagreements about the meaning of the right to health resulted in confusion as to the legal status of this right.<sup>135</sup>

Third, it is important to note that medical professionals have played an important role in the interpretation of the right.<sup>136</sup> Their contribution, however, caused two main problems. Initially, by focusing on the purely medical meaning of health, they ignored other fields that influenced the right to health, particularly legal issues. In terms of medical professionals' effects on the language of the right to health, the WHO definition of health, as Chapman notes, has affected their understanding, which was in conflict both with the reality of health and the state of scientific development at that time.<sup>137</sup> As a result of this situation, states did not treat this right seriously. Explicating the legal basis of the right to health is, however, an important way to encourage states to recognize that the right to health is not only 'charitable work' by the government but is also a legal obligation that

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<sup>132</sup>Tom Campbell et al., *Human Rights: From Rhetoric to Reality* (Basil Blackwell, 1986). 52

<sup>133</sup>*Ibid.* 53

<sup>134</sup> Some treat health as political issue rather than legal matter see Jean Carmalt and Sarah. 2004. the right to health in the United States of America What does it mean?. Center for economic and social rights. 2

<sup>135</sup> See A. R. Chapman, "Violations of the Right to Health," *Health* 3(1977). 87-92

<sup>136</sup>Dennis and Stewart, "Justiciability of Economic, Social, and Cultural Rights: Should There Be an International Complaints Mechanism to Adjudicate the Rights to Food, Water, Housing, and Health?." 481 see also P. Alston, "United Nations' Specialized Agencies and Implementation of the International Covenant on Economic, Social, and Cultural Rights," *Colum. J. Transnat'l L.* 18(1979).

<sup>137</sup>Chapman, "Violations of the Right to Health." 88

states have and must comply with. This legal obligation requires the state to take it into account in making and implementing health regulation and policy.

As we have seen, it seems obvious that human rights, including any right to health, cannot be implemented until they are appropriately described. The form of words will help to clarify the expectations of the right. In other words, individuals, states and others, including courts, will be able to identify the parameters of the right and what they can expect to gain from its vindication. For the purposes of this thesis, it is necessary to formulate a definition of the core of a right to health and evaluate its status as a human right and in particular its justiciability. Otherwise, any human right will be ambiguous and open to different interpretations and expectations.

To translate rights into reality, Orucu argues that “their scope and the ways in which they can be utilised have to be determined and shown; in other words, they have to be regulated. This approach of regulating a right defines and strengthens it.”<sup>138</sup> With this in mind, it is important to note that having a right requires having all of the necessary preconditions for its implementation. One of these preconditions is clarity in the language which describes and defines the core of the right, and facilitates its legal protection. Courts, particularly constitutional courts, usually focus on the core of right and ensure that that core has not been touched. It is, therefore, argued, in agreement with Orucu, that every right requires a defined core and explicit criteria for recognising encroachments. In Orucu’s words, “only then would the core have solid content and each right an essential definition.”<sup>139</sup>

Having identified that one main problem of accepting the existence of a right to health is the language used to describe it, it is important to resolve this to ensure that the basis and content of the right are both clear and its legal status is clarified. In order to offer a solution this thesis proposes three ways forward. The first concerns what has been argued to be an inappropriate separation of rights into two different sets, implying the supremacy of one over the other and affecting their status.

Current international circumstances in fact encourage members of international society to reunite these two sets of rights.<sup>140</sup> Globalisation or the world village should not be confined

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<sup>138</sup>Campbell et al., *Human Rights: From Rhetoric to Reality*. 40

<sup>139</sup>*Ibid.* 55

<sup>140</sup>The Vienna Declaration of Human Rights 1993, see also Yamin, "The Right to Health under International Law and Its Relevance to the United States." 1156 and PEREIRA, "Live and Let Live: Healthcare Is a Fundamental Human Right." 431

to commercial issues such as free movement of goods or economic development. Rather, it should create and dedicate real attention to human rights issues. In fact, health, as has been indicated by a number of writers such as Schirnding, is one of the cornerstones of sustainable development. Without it, sustainable development cannot be achieved.<sup>141</sup> Thus, this may be a good time to revise the ICESCR and issue a new set of human rights without confusion or ambiguity. To achieve this, it is necessary, if not essential, to found all rights on a solid legal basis. Thus, states would have to treat all rights as equal, especially in terms of the legal nature of states' obligations. For instance, adopting the articulation of article (2) in the ICCPCR in the ICESCR would make a big difference to the way in which states act in terms of the latter convention. First, it will terminate the argument about the differentiation between these two sets of rights. Second, and as result, the implementation of social and economic rights would be possible and legal remedies could be applied. But, even with the current situation, terms and articulation of article 2 of the ICESCR, such dilemma should not be understood in a way that deems socioeconomic rights as non-binding rights or non-real rights.

However, there is an uncertainty about the nature of economic and social rights and if considered as real human rights, as already noted, they could probably be treated as legal rights. Thus, economic and social rights no doubt include a legal obligation but the question here is about the nature of this legal obligation and whether it is an obligation of result or an obligation of conduct. In terms of both obligations, states would be responsible for providing health services to citizens. In fact, states are required in certain circumstances such as emergency cases or spreading diseases to do their best to achieve these rights in light of an obligation of result rather than an obligation of conduct.

The second suggestion, if clear language is adopted, is that an appropriate legal framework for vindication of the right is established, but this may require the opening of new negotiations between the UN members and the adoption of a treaty by a resolution of international organisation. In terms of international law, recently we have witnessed a new method "consensus" (sometimes called 'general agreement') of adopting international treaties by resolutions of the UN General Assembly (GA) or any other international

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<sup>141</sup>Report of international bank, the UN General Secretary speech in Johannesburg, the muliluom goals report. See also Y. Von Schirnding, "The World Summit on Sustainable Development: Reaffirming the Centrality of Health," *Globalization and Health* 1, no. 8 (2005). 3, R. Hammonds and G. Ooms, "World Bank Policies and the Obligation of Its Members to Respect, Protect and Fulfil the Right to Health," *Health and Human Rights* 8, no. 1 (2004). 34- 42

conference and organisation.<sup>142</sup> This general agreement about the subject of the treaty will help us to make real progress, and avoid the constitutional need to sign or ratify an additional international agreement.

To date, the language used in international human rights agreements to define a right to health and recognise it as human right is still vague which results in confusion and false expectations. Clarification of this language is also problematic because identical interpretations cannot be guaranteed since the words used may have different meanings in different languages. However, this problem is not unique to a right to health. Thus, agreeing on a reasonable and achievable right to health may rely on a clear governmental policy and judicial review rather than on the implementation of international human rights law.

## **1.7 A Proposed Solution**

This attempt is not the first time that a definition of a right to health has been suggested. For example, Professor Goler Teal Butcher defined the right to health as “a claim, interest, need, or demand which is cognizable under law and which proceeds from moral precepts necessary for respect for human dignity.”<sup>143</sup> With respect to Butcher, this definition is questionable and increases the disagreement that already exists about the content and scope of the right to health, especially in regard to its nature and legal basis. First, this definition brings us back to the question about what is meant by a ‘right to health’ and the extent to which it is equivalent to a right to be healthy; the latter not being achievable. Secondly, this concept also raises the interrelationship between health as a human right and other issues such as environment, food and education, which has already reflected negatively on the implementation of the right to health.

Moreover, it seems that Butcher, as an American, still believes that the right to health is a moral, rather than a legal, right. Any attempt to identify health as a ‘full’ right should focus on its legal status and the obligations of the state to provide, supervise and guarantee its quality as well as to respect, to protect and to fulfil the right for all citizens. Accordingly, our proposed definition aims to avoid terms such as moral precept, interest and demand and will focus on its legal basis.

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<sup>142</sup>A. Aust, *Modern Treaty Law and Practice* (Cambridge Univ Pr, 2007). 85-89

<sup>143</sup>In Jamar, "International Human Right to Health." 15

It is also important to note that the proposed definition does not mean inventing an entirely new phrase. The proposed definition is based on the phrase the 'right to health care', which is not often used in the international documents, although it has been employed by some jurists, albeit in different ways.<sup>144</sup> In this thesis, the right to health care falls somewhere between the wider phrases the 'right to health' and the narrower term, the 'right to medical care'.

As has been discussed, and will be further considered below, the use of this terminology will avoid the disagreement generated by alternative conceptualisations of the right. First, it will clarify the target that states are required to achieve so that there will not be confusion with other elements which currently appear to be unconnected directly to health care or should not be connected to health care. Second, limiting health care to preventive and curative programs will assist citizens in knowing their rights and the limitations that might exist on these rights so that their expectations will be rational. Therefore, a right to health care will not be confused with other related rights such as the right to food or the right to housing. Third, the proposed definition assumes that, in case of a challenge in courts, judges will be able to adjudicate on a clear and unambiguous concept. Fourth, this proposal may not fully elevate the right to health care to the status of a full human right, but it should assist in understanding the obligations of the state which are clear whether health care is treated as human right or only as a legal duty on the state.

From the above evaluation of the phrases currently used to describe the right, it has emerged that none of them offers a clear and definite concept of right to health. In fact, they are wide, confused and incomplete concepts.<sup>145</sup> As a result, recognising health as a human right at the very least would require the formulation of a definition that can be used to describe this right in terms of law and avoid the confusions of the other definitions. Halley has argued that it "seems that a narrowly defined right to health care would answer

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<sup>144</sup> Those jurists have seen the phrase right to health care from different angles so some like have criticised this term and thought it is not the right phrase for expressing such right. Others went to different direction by saying that it is the right phrase to use if we want to accomplish realistic right to health care that is possible to apply.

<sup>145</sup> This was obvious conclusion of the right to health in Americans where all the above phrases were analysed see Fuenzalida and Scholle-Connor, "The Right to Health in the Americas: A Comparative Constitutional Study."

these questions. The problem, of course, lies in reaching a consensus upon the definition.”<sup>146</sup>

It should be clear that the definition proposed here is not perfect, nor may it be universally agreed. However, having reviewed the alternatives, it is argued that the “right to health care” is a preferable concept. In contrast with the other terms, the content of a ‘right to health care’ is both more realistic and more inclusive, focusing on direct and clear elements such as preventive and curative programs.

This conclusion is based on several grounds. First, we have already seen that there is no agreement internationally about what is meant by a human right to health, and there are various terms used in international treaties which do not assist in clarifying the content of the right. This may be a result of the definition of health adopted by the WHO, which influenced all other formulations of the right in other international documents. As a result, the international community adopted a broad concept of the right to health which actually embraces other related human rights. Thus, the focus has been on these other, related, human rights rather than on the right to health care. These rights have now become independent rights while the status of the right to health care is still complicated. To clarify, it is common for the right to food or a safe environment to be discussed under the right to health, yet these have their own dedicated international organizations or programmes, such as the Food and Agricultural Organization of the United Nation (FAO) or the United Nations Environment Programme (UNEP). While there is a link between these rights and the right to health care, they are not one right. If they were, it would seem unnecessary to have established two international institutions and two Special Rapporteurs dedicated to them.<sup>147</sup>

Clarification of the right to health care would result in compelling states to deal with it as they do with other basic social goods. States cannot rely on a lack of resources to deny basic social goods, the provision of which is considered a main reason behind the existence

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<sup>146</sup>V. M. Halley, "Right to Health Care: Key Policy Issue or Useless Concept?," *Kan. JL & Pub. Pol'y* 3(1993). 106

<sup>147</sup>See for example Special Rapporteur on the right to food, available at <http://www.ohchr.org/EN/Issues/Food/Pages/FoodIndex.aspx> accessed 30/09/2012 and Special Rapporteur on the implications for human rights of the environmentally sound management and disposal of hazardous substances and wastes, available at <http://www.ohchr.org/EN/Issues/Environment/ToxicWastes/Pages/SRToxicWastesIndex.aspx> accessed 30/09/2012

of the state itself.<sup>148</sup> In her seminal article Pereira rejected the US government's denial of a right to health care for economic reasons. In the long run, the division of human rights into civil and political rights and economic, social and cultural rights is, she argues, not acceptable.<sup>149</sup>

In another opinion, Czeresnia, believes that "[t]he right to health means the state's guaranteeing decent living conditions and universal and egalitarian access to measures and services for the promotion, protection, and recuperation of health, at all levels, to all inhabitants leading to the full development of the individual human person."<sup>150</sup> But the previous explanation also makes the right to health care appear very wide and effectively impossible to realise. On the other hand, conceptualizing a right to health care succeeds, not least because it encompasses both preventive and curative programmes. Each of these is made up of various constituent elements such as hospital services, medication and medical technologies in relation to the curative program and also, for example, vaccines in the preventive program, to be delivered in line with other fundamental principles such as non-discrimination, accessibility, availability, participation and so on, which will be considered *infra*. These principles are very important for both health providers including governmental institutions and citizens, especially in case of conflict.

According to Cropley, these elements of the right to health care are acknowledged even by people who believe that health care is a commodity and so should be left to market forces.<sup>151</sup> However, there are still problems facing the implementation of the right to health care in both theory and practice. These problems can be divided into three types. First, the linkage of the right to health care with other related human rights, such as food, education and environment, has generated a potential conflict between the rights. Therefore, prioritisation of one set of rights over the other is problematic, and has resulted in states focusing on the related rights rather than the right to health (care).

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<sup>148</sup> See in relation to this point A. Weale, "The Right to Health Versus Good Medical Care?," *Critical Review of International Social and Political Philosophy* 15, no. 4 (2012). Cassel, "Right to Health Care, the Social Contract, and Health Reform in the United States." 53-64

<sup>149</sup> This is clear in Pereira's article. In this article Pereira strongly criticizes the USA government for not ratification human rights treaties and its attempts in persuasion Americans in that political and civil rights are only human rights. for detailed discussion see her article, PEREIRA, "Live and Let Live: Healthcare Is a Fundamental Human Right." 481-503

<sup>150</sup> D. Czeresnia, "The Concept of Health and the Difference between Prevention and Promotion," *Cadernos de Saúde Pública* 15, no. 4 (1999). 705

<sup>151</sup> N. E. Cropley, "American Right to Health Care-an Idea Whose Time Has Come, the; Cropley, Nancy E.," *Golden Gate UL Rev.* 20(1990). 687

For example, the right to housing or the right to education has been given more attention than the right to health (care) in most states. As a result, health as a human right has not only suffered from a lack of resources for its implementation in some states, but where resources are available they may be diverted towards the realisation of these other rights rather than health care. In other words, health care has been listed in second place even within the set of social and economic rights. In terms of implementation, the state, as pointed out by Osiatynski, requires to devote part of its budget to health needs.<sup>152</sup> He also argued that a legal right to health care would mean that health care decisions are not only made by the legislature and executive bodies, but also by the judiciary.<sup>153</sup> In other words, according the appropriate legal status to the right would enable individuals to challenge the failure of states to vindicate it.

The second problem is the linkage of the right to health care with other social problems: economic, cultural and political rights. However, although these issues surely have some influence on health, it should be clear that this does not mean that the right to health care can be ignored or avoided completely. Writers such as Freidman believe that there are several factors such as economic, cultural and political elements which play a fundamental role in implementing the right to health, and accordingly that health should be treated as other goods and left to market forces.<sup>154</sup> In response to this view, many studies, as already noted, have shown that all human rights are expensive, whether they are negative or positive rights. Therefore, recognition of the right to health care, as a basic social good, even if not considered as human right, assumes that the state will do its best to provide it for every citizen. As has been pointed out by Evans and Roos, money does not buy health.<sup>155</sup> Therefore, while economic factors might affect the application of the right to health care they cannot reduce its importance. To clarify, the state is obliged to fulfil the right to health care whatever its situation and in general the state cannot discriminate in dealing with human rights.

In terms of international human rights law in general, the state is required to respect its legal obligations, otherwise it can be held accountable. Arguably, it could be said that the implementation of the right to health care does not inevitably depend on the economic

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<sup>152</sup>W. Osiatynski, "Rights in New Constitutions of East Central Europe," *Colum. Hum. Rts. L. Rev.* 26(1994). 111-165

<sup>153</sup>*Ibid.*

<sup>154</sup>D. Friedman, "Should Medicine Be a Commodity? An Economist's Perspective," *Rights to Health Care* 38, no. V (1991). 259-305

<sup>155</sup>R. Evans and N. P. Roos, "What Is Right About the Canadian Health Care System?," *The Milbank Quarterly* (1999). 395-396.

situation or available resources in the state. Having a good health care system does not essentially rely on how much money a country can spend on health care.<sup>156</sup> Evidence suggests that there are many countries with a scarcity of resources which nonetheless have a high level of health care, such as Cuba.<sup>157</sup>

In terms of definition, the right to health care can encapsulate the values expressed by concepts such as the right to medical care, the right to health and the right to health protection. Use of the term 'right to health care' can help to avoid the criticisms of these terms that were highlighted above, and assist in achieving the required balance between the enjoyment of the right and the capacity of the state to provide it. As explained above, providing a clear meaning of the right to health care would resolve the problem about its legality and allow the judiciary to participate properly in its elucidation, interpretation and enforcement. Looking closely at General Comment No 3 paragraph 10, it is clear that there is a sense of obligation on states to ensure the satisfaction of at least the minimum level of each right included in the ICESCR.<sup>158</sup>

The third problem is the structure of the right to health care. The vague language used historically to explain the nature of rights in health has generated confusion as to what any such right might encapsulate. Using the language of a right to health care focuses the right on specific and clear goals. As Salomon has pointed out, if health is defined too broadly this would result in the healthcare system and the relevant Ministry being responsible for an inappropriately wide range of human activities.<sup>159</sup> Establishing a clear concept of the right to health care, or at least acknowledging its contents, will contribute to facilitating the development of health policies which can be applied in such a way as to respect the principles which aim to achieve goals such as justice and non-discrimination.<sup>160</sup> Explicitly establishing the concept of a right to health care might require a new formulation that can modify and refine the current conceptions. This might not be easy. In this regard, scholars

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<sup>156</sup>J. F. Blumstein, "Health Care Law and Policy: Whence and Whither," *Health Matrix* 14(2004).39

<sup>157</sup>A. Menon-Johansson, "Good Governance and Good Health: The Role of Societal Structures in the Human Immunodeficiency Virus Pandemic," *BMC International Health and Human Rights* 5, no. 1 (2005). 7-8, F.E. Sixto, "An Evaluation of Four Decades of Cuban Healthcare" (2002). 340-342 accessed 19/08/2012, [http://www.centerforurbanstudies.com/documents/electronic\\_library/cuba/healthcare/an\\_evaluation\\_of\\_our\\_decades\\_of\\_healthcare.pdf](http://www.centerforurbanstudies.com/documents/electronic_library/cuba/healthcare/an_evaluation_of_our_decades_of_healthcare.pdf), P.G. Bourne, "Asking the Right Questions: Lessons from the Cuban Healthcare System," *Health Equity Network Lecture. London School of Economics and Political Science* (2003). 12

<sup>158</sup>General Comment No 3. See also discussed details about this point in WHO. The right to health, fact sheet no 31, at 23, on line at <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf> accessed 07/11/2012

<sup>159</sup>In Bok, "Rethinking the Who Definition of Health." 12, see also General Comment No 14

<sup>160</sup>M. Whitehead, "The Concepts and Principles of Equity and Health," *International Journal of Health Services* 22, no. 3 (1992). 15

disagree about how this modification could be accomplished because each has his own interpretation of the meaning of the right to health care in light of the international document he or she supports. For example, Ely Yamin suggests that the Alma Ata declaration should be used as the minimum standard of health care.<sup>161</sup> In Halper's view the definition of the right to health care can be captured by two components: "it is an obligation on the part of society, negatively or procedurally, not to interfere with the individual's pursuit of health care and, positively or substantively, to provide that care when the individual demands it."<sup>162</sup> In order to explore how the right to health care can be implemented, it seems relevant to take the above views into account.

If it is to avoid the same problems as the other definitions referred to earlier, the right to health care needs to be clarified and refined in order to become a theoretically and practically explicit notion. The following definition is intended to explain the nature and scope of the proposed right to health care which will be used throughout this thesis.

The right to health care is the legal right that obliges the state to provide health care services to its citizens in accordance with its international and national obligations under international and domestic law. It also includes the duty to establish and supervise the necessary institutions for implementing the right and to impose health regulations to improve health care standards within and without the country.

The proposed definition is aimed at creating a clear concept that can help to address the problems that have plagued other efforts at definition. Under this definition, the characteristics of the right to health care are clarified. As will be explained below, this conceptualisation of the right is both workable and enforceable. It is not only an aspirational goal but it is also a real target that can be achieved. In terms of terminology, the hypothetical definition encompasses at least three fundamental characteristics. First, it is workable theoretically and practically. Second, it is a legal right that would be protected by law and legal sources nationally and internationally in such a way that courts would be able to ensure the right of everyone to attain the appropriate human right to health care, if the government did not offer it at the appropriate time. No one can ignore the importance of the right to health care, not only as a human right but also as being clearly positioned at

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<sup>161</sup>A. E. Yamin, "Defining Questions: Situating Issues of Power in the Formulation of a Right to Health under International Law," *Hum. Rts. Q.* 18(1996). 400

<sup>162</sup>Thomas Halper, "Rights, Reforms, and the Health Care Crisis: Problems and Prospects Rights to Health Care," ed. Thomas J. Bole and William B. Bondeson, *Philosophy and Medicine* (Springer Netherlands, 1991). 135

the heart of social justice in general.<sup>163</sup> Moreover, there is general agreement that other human rights such as the right to life cannot be enjoyed without a human right to health care. The third is justiciability which will be discussed in the following chapter. Meantime the first two characteristics of the right to health care will be discussed in more detail in the following subsection.

## 1.8 Characterisation of the Proposed Definition

Initially, it is important to note that this description is not completely new. Rather what follows is an attempt to develop a concept of health care that can be recognised as a full legal right, thereby circumventing the somewhat barren debate about negative and positive rights.

With regard to the legal right to health care, this definition will help to build the causeway towards the realisation of adequate or appropriate health services. As noted above, researchers believe that the right to health care is at the centre of constitutional rights and it has an influence on both civil and political rights as well as on economic, social and cultural rights.<sup>164</sup> In addition, it has been argued that it is unreasonable to restrict the definition of human rights to political rights. Pereira has explained how the government of the USA uses the term ‘human rights’ in a way that limits its focus on political and civil rights.<sup>165</sup> To avoid this problem, the characterisation of the right to health care will be discussed in the following sector.

### 1.8.1 Rights

As has been acknowledged above, calling health care a legal right is controversial. For a number of reasons, many scholars believe that conferring the status of a right on health care is problematic.<sup>166</sup> For example, it could be argued that it makes no sense to call health care a human right because of the lack of meaning and uncertainty in regard to the international concept of the right to health care. Second, it is likely to be unenforceable,

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<sup>163</sup>N. Daniels, "Justice and Access to Health Care," (2008). Available on line at <http://www.science.uva.nl/~seop/entries/justice-healthcareaccess/> accessed 23/09/2012

<sup>164</sup> For further details one could see these articles. Asher et al., *The Right to Health: A Resource Manual for Ngos*. 7 and Hervey, "The ‘Right to Health’ in European Union Law." 195

<sup>165</sup>PEREIRA, "Live and Let Live: Healthcare Is a Fundamental Human Right." 422

<sup>166</sup>M. Greco, "The Politics of Indeterminacy and the Right to Health," *Theory, Culture & Society* 21, no. 6 (2004). 1

because of a lack of resources or in regard to its uncertain terms.<sup>167</sup> In order to explore the nature of the right to health care as a legal right, it is important to note that, in terms of law, and as pointed out by Halley, if something is called a right, there are two features that have to exist. On the one hand, in Halley's words, "A legal right is an entitlement to a benefit that can be justified (and thus enforced) by an appeal to laws of the state".<sup>168</sup> This simply means that a right ought to be protected by law and law should be understood in a wide sense. For example, law might mean constitutional law, legislation, regulation, and/or decisions of the courts. It could also be rooted in international agreements or decisions of international organisations. In regard to enforcing a "common moral vision", as Buchanan puts it, the moral vision in terms of providing health care to the citizens must be established as a legal right: it is not enough simply to retain it as a moral right.<sup>169</sup>

The second feature is that the right must be restricted and classified in a way that allows individuals, states and courts, if necessary, to recognise its content. As has been noted by Cranston, the difference between moral rights and human rights is that the latter are called human rights because they belong to people simply because of their nature.<sup>170</sup> Equally importantly, recognition of a legal right entitles its bearers to challenge the provider – in this case the state. In other words, acceptance that the right to health care is a legal right requires that there are legal mechanisms available to protect individuals from any violation of the right, even by their own state authorities.<sup>171</sup> Wasserstrom argues that for something to be a human right, it should have at least four characteristics:

First, it must be possessed by all human beings, as well as only by human beings. Second, because it is the same right that all human beings possess, it must be possessed equally by all beings. Third, because human rights are possessed by all human beings, we can rule out as possible candidates any of those rights which one might have in virtue of occupying any particular status or relationship, such as that of parent. And fourth, if there are any human rights, they have the additional characteristic of being assertable against the whole world. That is to say, because

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<sup>167</sup> Robert Rhodes, states that whether the phrase we use to indicate health care as right may lead to injustice if we considered it as need see more about his view in Halley, "Right to Health Care: Key Policy Issue or Useless Concept?." 106

<sup>168</sup> Ibid. 103

<sup>169</sup> Ibid. 104

<sup>170</sup> B. G. Ramcharan, "Concept of Human Rights in Contemporary International Law," *Can. Hum. Rts. YB* (1983). 272

<sup>171</sup> The importance of existence of national mechanisms such for monitoring the implementation of national health policy, and of course the courts is on the top of them, was mentioned in the general comment no 14

they are rights that are not possessed in virtue of any contingent status or relationship, they are rights that can be claimed equally against any and every other human beings.<sup>172</sup>

These characteristics, specifically the first, the second and fourth, enhance the legal status of the proposed right to health care. Moreover, these characteristics will play an essential role in showing the connection between the right to health care and human rights principles in general. As has been mentioned above, health care is not only a fundamental human right but other human rights are influenced by its implementation. However, even if this is accepted, the traditional approach of international human rights law makes it difficult to envisage how it might be recognised as such without a considerable change in approach from the international community. This, however, does not detract from its importance to individuals and communities and, as will be seen, particularly in chapter 4, the proposed right can be protected not necessarily by human rights law, but by national and supranational recognition of its status as a legal right – even if it is not always dealt with as a stand-alone right. Therefore, in what follows, the focus will be on the right to health care as a legal right

Any postponement in the implementation of a right to health care results in other human rights being affected negatively. It is not enough for both national and international communities to adopt or enact agreements or legislation stating that health care is a human right. It is also necessary to build mechanisms that facilitate its enforcement. The legal right to health care entails state intervention in regulating, providing, and supervising health care services for its population. This does not involve only government or health organisations but also the judiciary and legislative institutions<sup>173</sup> as well as the private health sector. From a legal perspective, the state is also required to undertake all necessary steps to ensure that this right is provided to the population with full respect for human rights principles. On the other hand, some researchers believe that it might be better if the right to health care was seen as a duty of the state rather than as an individual's right.<sup>174</sup> In their opinion, social rights, including health care, cannot be described as individual rights because the state is required to take positive action, and sometimes exceptional action such as restricting freedoms and entitlements. From this perspective the responsibility of the

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<sup>172</sup>Ramcharan, "Concept of Human Rights in Contemporary International Law." 272

<sup>173</sup>A. Littell, "Can a Constitutional Right to Health Guarantee Universal Health Care Coverage or Improved Health Outcomes: A Survey of Selected States," *Conn. L. Rev.* 35(2002). 294

<sup>174</sup>Fuenzalida and Scholle-Connor, "The Right to Health in the Americas: A Comparative Constitutional Study." 598

state to provide health care services to its citizens can be based on the idea of a social contract. As Cassel says:

The fundamental idea of the social contract is that persons come together in a society and give up some liberty rights and some private property (as in the case when we pay taxes) in order to allow the state to do for people some things that they cannot do as well for themselves. Good examples include the building of interstate highways, and the maintenance of police forces, and national security.<sup>175</sup>

However, it is argued here that the practical and symbolic value of the language of rights is a valuable tool in encouraging states to respect and implement health care strategies. This enhances, rather than conflicts with, the idea of a social contract.

### **1.8.2 Workability**

In 1994, Jamar pointed out that it is impossible to define the right to health or find out what it means without articulating it in a way that is useful, workable and effective in the light of the present international human rights agreements.<sup>176</sup> From a human rights perspective, workable means that the right is an achievable and practicable target. Moreover, if a workable definition can be found, the right moves closer to becoming a full right. In simple terms, where is a right, there is a remedy. A workable definition will clarify how a state should act in order to fulfil its obligations under international human rights law. Consequently, enforcement of these obligations by the state requires the government to undertake all the necessary steps that ensure implementation of the right to health care in national health services and policy. In other words, the state ought to deal with the right to health care not only as an international obligation but also as part of its own political and legal system.<sup>177</sup> In this sense, it is important to consider what Sprumont says; namely that “as long as the content of the right to subsistence and subsequently the right to health care cannot be extended substantively, the obligation imposed on the state to guarantee a minimum standard of care remains more political than legal”.<sup>178</sup> Once Sprumont’s concerns have been met, as it is argued has been achieved with the proposed definition of

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<sup>175</sup>Cassel, "Right to Health Care, the Social Contract, and Health Reform in the United States." 56

<sup>176</sup>Jamar, "International Human Right to Health." 3

<sup>177</sup>C. Chinkin, "Health and Human Rights," *Public health* 120(2006). 53

<sup>178</sup>Sprumont, "Unwritten Constitutional Right to Subsistence Brief Comment of 27 October 1995 Judgment of the Swiss Federal Court in the Perspective of a Right to Health Care." 414

the right in this thesis, not only does the right take shape but it also, as will be discussed *infra*, empowers citizens to challenge a failure of delivery.

Given what has been said before, however, it is clear that health care has not yet been treated as a human right in international law. However, in what follows it will become clear that in countries such as the United Kingdom an approach to health care has developed that recognises its status as an important and significant interest, allows for citizens to challenge government decisions in this area and respects health care as a universal value. In practice, therefore, the UK has developed an approach that accords to health care some of the characteristics that would also be found were it fully recognised as a human right. Thus, while the traditions of international law do not yet accept health care as a human right, an analogous right can emerge - given Government will - that elevates health care claims from mere aspirations into vindicable and justiciable interests. That this is possible has implications for other states – in this thesis its potential impact on Libya will be considered in more depth later. Recognition of the right to health care as proposed here not only facilitates its implementation but also situates it as a justiciable legal right, thereby ensuring that legal challenge by disaffected citizens is possible where the core elements of the right are clear.

## **Chapter II: Sources and Justiciability**

## 2.1 Introduction

The legal status of the proposed right to health care depends on its sources. As is well known, sources of international law are divided into two categories: formal sources and material sources.<sup>179</sup> Both sources are important but for the purposes of this thesis, formal sources will be focused on in an effort to clarify the legal status of the proposed right to health care.<sup>180</sup> As is well known, the formal sources, as described by Brownlie, are “the legal procedures and methods for the creation of rules of general application which are legally binding on the addressees.”<sup>181</sup> Thus, formal sources provide the legal basis of the right claimed

This section will be divided into three subsections. The first will study the relationship between sources of international law and the proposed right to health care. The second will investigate the influence of these sources in states and what states are supposed to do under the obligations generated by them. Finally, the third subsection will explain what is referred to as ‘soft law’ and explore whether this can be used by the judiciary as a source of international law or not, and if so, what effect soft law will have on court decisions on claims for a right to health care.

## 2.2 The Relationship Between Sources of International Law and the Right to Health Care

As with other situations, the right to health care must be derived from legal sources, regardless of whether these are national or international. In terms of human rights law and as an international norm, the sources of international law are considered here because of their effects on states, as they show how states should implement their obligations, and what will happen if they fail to do so.

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<sup>179</sup>M. Dixon, *Textbook on International Law* (Oxford University Press, USA, 2007). 25, Malcolm D. Evans, *International Law*, third edition, Oxford University Press, 2010, 96-97, Ian Brownlie, *Principle of Public International Law*, 7<sup>th</sup> edition, Oxford University Press, 2008, 3

<sup>180</sup>Richard K Gardiner, *International law*, Pearson Education Limited, 2003, 25

<sup>181</sup> Ian Brownlie, *Principles of International Law*, seventh edition, Oxford University Press, 2008, 3 see also Daniel Moeckle and Others, *international Human Rights Law*, Oxford University Press, 2010, 105

As has been explained above, the focus will be on sources that could play, or have played, a fundamental role in the genesis and potential emergence of the proposed right to health care. This underlines the fact, already discussed, that although these sources can play an essential role in supporting a right to health care, they are not entirely unproblematic. For example, it has already been argued that the language of human rights can result in confusion because of the differences between states in terms, for example, of culture, language and ideology. Nonetheless, states are expected to agree to the same conventions and, presumably, act on them in the same way.

Before beginning discussion of the main issue, a number of points need to be made. First, the sources of international law will not be discussed in the traditional order contained in Article (38) of the International Court of Justice (ICJ) Statute.<sup>182</sup> Rather, they will be discussed in respect to their importance to the proposed right to health care. It may, therefore, not be necessary to consider all possible sources. For example, international customary law may not play a fundamental role, while court decisions may do. Therefore, the focus will be only on sources that can illustrate the legal status of the right to health care and that have played a major role in this context. Second, focusing on these sources does not imply that other sources are not important, or may not become important, but to date they have not played an important role in the development of this right. This discussion will explore three sources of international law. The first is international conventions; the second is judicial decisions, and the third is academic commentary.

## 2.2.1 International Conventions

International conventions, as stated in article (38) of the ICJ Statute, may be used by the International Court of Justice to assist in adjudicating claims.<sup>183</sup> The order in which these appear bears no direct relationship to the priority to be accorded to them. According to

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<sup>182</sup>The Statute of the International Court of Justice, article 38 available at: [http://www.icj-cij.org/documents/index.php?p1=4&p2=2&p3=0#CHAPTER\\_II](http://www.icj-cij.org/documents/index.php?p1=4&p2=2&p3=0#CHAPTER_II) accessed on 27/09/2012 See also in general S. Omar, "Sources of International Law in the Light of the Article 38 of the International Court of Justice," *Available at SSRN 1877123* (2011).

<sup>183</sup>Statute of International Court of Justice. Article 38. '1. The Court, whose function is to decide in accordance with international law such disputes as are submitted to it, shall apply: a. international conventions, whether general or particular, establishing rules expressly recognized by the contesting states; b. international custom, as evidence of a general practice accepted as law; c. the general principles of law recognized by civilized nations; d. subject to the provisions of Article 59, judicial decisions and the teachings of the most highly qualified publicists of the various nations, as subsidiary means for the determination of rules of law. 2. This provision shall not prejudice the power of the Court to decide a case *ex aequo et bono*, if the parties agree thereto.' Available at <http://www.icj-cij.org/documents/index.php?p1=4&p2=2&p3=0> accessed 27/09/2012

Dixon, for example, “there is no indication in Article. 38 of the priority or hierarchy of the sources of international law.”<sup>184</sup> Generally, there is agreement that international sources of human rights are the same as the sources of international law in general. This means that Article 38 of the International Court of Justice Statute can be used to identify the sources that should be utilised. Historically, there is agreement among theorists that custom was the original and the first source of international law.<sup>185</sup> But practically, it seems that the conventions are often considered as the first.<sup>186</sup> In general, there is agreement that the use of human rights terminology and the notion of ‘Universal Rights’ emerged during the preparations for the establishing of the United Nations.<sup>187</sup> In addition, the phrase ‘human rights’ was clearly used in 1948 when the Universal Declaration of Human Rights (UDHR) was adopted by the UN General Assembly. While the UDHR is considered as a non-binding agreement, there are international lawyers who regard it as part of international customary law.<sup>188</sup> In terms of international human rights law, special attention is paid to international conventions; in particular, following the Second World War, to international declarations and treaties.

The Vienna Convention on the Law of Treaties, establishes that a treaty is “an international agreement concluded between states in written form and governed by international law, whether embodied in a single instrument or in two or more related instruments and whatever its particular designation.”<sup>189</sup> It is important to remember that treaty, here, is taken to mean all forms of written agreement that states may use to organize their relations; the term, therefore, includes international agreements, covenants, declarations and conventions. Because of the new role of human rights in international law, treaty law has played an important function. Internationally, therefore, human rights are based upon treaties, which became the main international instrument. However, the use of international treaties increased after the Second World War, and it seems that there is more than one sort of treaty. International treaties have been divided into two categories.<sup>190</sup> The first category

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<sup>184</sup>Dixon, *Textbook on International Law*. 24 see also I Brownlie, *Principle of Public International Law*, 7th ed. (Oxford University Press, 2008)., 5

<sup>185</sup>H. G. Cohen, "Finding International Law: Rethinking the Doctrine of Sources," *Iowa L. Rev.* 93(2007). 79

<sup>186</sup>*Ibid.*, 77

<sup>187</sup>F. Haigh, "Human Rights Approach to Health," *Public Health* 43, no. 2 (2002).166-67 see also

<sup>188</sup>Dixon, *Textbook on International Law*.346 and V. A. Leary, "The Right to Health in International Human Rights Law," *Health and Human Rights* 1, no. 1 (1994).32

<sup>189</sup> Vienna Convention, Art (2-a). Available on line at [http://untreaty.un.org/ilc/texts/instruments/english/conventions/1\\_1\\_1969.pdf](http://untreaty.un.org/ilc/texts/instruments/english/conventions/1_1_1969.pdf) accessed 25/02/2009

<sup>190</sup>Brownlie, *Principle of Public International Law*. 13-14

is a law-making treaty, which can produce rules that legislate or create general international rules binding on states parties, and sometimes non-state parties, if they are treated originally as customary law.<sup>191</sup> However, there is a general rule of international law - which is corroborated by article 34 of the Vienna Convention on the Law of Treaties 1969 - that treaties cannot bind third parties without their consent. Some scholars believe that the enforcement of treaties on third parties does not derive from the treaty itself but rather because that particular rule derives from customary international law.<sup>192</sup> The second category is contract treaties, which usually organize the relationship between two parties, and they do not produce legal obligations.

To return to the proposed right to health care, it can be seen that variations on this right are often included in making-law treaties such as the Universal Declaration of Human Rights, the International Covenant on Economic, Social, and Cultural Rights, the Convention on the Rights of the Child and the American Convention on Human Rights. While the language and concepts used in these treaties have already been argued to be insufficiently precise, since each of them contains some elements of what has been described here as a right to health care, they remain relevant to this discussion. Second, and most importantly, articulation of the right to health care in a law-making treaty could and should formulate general principles of law and customary rules, which would obligate all states, including those who have not signed or ratified any international agreement on this subject.<sup>193</sup>

It is important to note that the differences between these two types of treaties (law-making treaties and contract treaties) do not mean that a contract treaty cannot be used to establish new customary rules. In general, it is believed that customary international law could be generated by all actions of states, including a bilateral treaty.<sup>194</sup> According to the International Law Committee, customary international law might be instituted by different states' international activities; one of these is international agreements in general.<sup>195</sup>

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<sup>191</sup>Ibid. 14

<sup>192</sup>H. Tim, "Sourcebook on Public International Law," (Cavendish Publishing Limited), London, 1998). 83. See also Malcolm D. Evans, *International Law*, 3 ed. (Oxford University Press, 2010). 145

<sup>193</sup>Dixon, *Textbook on International Law*. 75-76

<sup>194</sup>Brownlie, *Principles of Public International Law*. 14 see also R. M. Maclean and H. L. Tutors, *Public International Law Textbook* (HLT Publications, 1995). 10

<sup>195</sup>Tim, "Sourcebook on Public International Law". 83 see also Brownlie, *Principle of Public International Law*. and Dimitrijevic, "Customary Law as an Instrument for the Protection of Human Rights." accessed on 29/04/2012

Focusing on the right to health care, international treaties played a fundamental role in raising awareness of rights in health and health care. Health is an essential social good for all nations. References to health care (however described) in international treaties began the process of the attribution of legal status, even although some commentators continued to see it as a moral rather than a legal value. In order to establish the legal status of the right to health care, therefore, international treaties cannot be ignored. International agreements are primary sources of rights and even where a challenge is to domestic behaviour, applicants will also generally appeal to international instruments to claim their rights, especially if the state where they make their complaint is a party to them.

This significant role of treaty in human rights is referred to for several reasons. First, human rights are a modern and universal issue, which began to be systematically developed following the Second World War,<sup>196</sup> and became one of the major projects of the Charter of United Nations. The importance and modernity of human rights implies that a treaty is a proper instrument to organize and declare human rights swiftly and clearly. In other words, the international community was not able to leave the development of human rights to other sources of international law, such as customary international law, which usually take a long time to develop, as will be explained later. Second, treaties are often written documents which make them clearer than other sources. Because of this clarity, treaties are used more and more by states to systematize international affairs. However, in some cases, states parties may fail to fulfil an international obligation even when it appears to have been accepted by the state authority because of their specific interpretation of the language in the treaty. Interpretation, therefore, can play an essential part in applying the obligations that derive from the treaty. However, it should be borne in mind that Article 31 of the Vienna Convention provides guidance on interpretation designed to minimise this potential difficulty.<sup>197</sup> In this context, the preparatory work and diplomatic documents of

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<sup>196</sup>L. Henkin, "International Human Rights as "Rights", " *Cardozo L. Rev.* 1(1979). ( 425-426

<sup>197</sup>Vienna Convention, Art (31) states that 1. A treaty shall be interpreted in good faith in accordance with the ordinary meaning to be given to the terms of the treaty in their context and in the light of its object and purpose.

2. The context for the purpose of the interpretation of a treaty shall comprise, in addition to the text, including its preamble and annexes:(a) any agreement relating to the treaty which was made between all the parties in connection with the conclusion of the treaty; (b) any instrument which was made by one or more parties in connection with the conclusion of the treaty and accepted by the other parties as an instrument related to the treaty. 3. There shall be taken into account, together with the context: (a) any subsequent agreement between the parties regarding the interpretation of the treaty or the application of its provisions; (b) any subsequent practice in the application of the treaty which establishes the agreement of the parties regarding its interpretation; (c) any relevant rules of international law applicable in the relations between the parties. 4. A special meaning shall be given to a term if it is established that the

the treaty can be used as a reference to interpret the treaty in case of disagreement between the States Parties during its implementation.<sup>198</sup>

In their judgments, national and international courts often refer to treaties when they deal with matters concerning health care.<sup>199</sup> In such cases, the courts have on occasion used a broad interpretation to afford legal protection. For instance, the European Court of Human Rights has not yet admitted the right to health care directly, preferring instead to see it as an aspect of the right to life, thereby offering it indirect but real protection.<sup>200</sup>

A treaty can also establish a mechanism for monitoring its application. Most importantly, this mechanism or body usually issues decisions or announcements in regard to the implementation of the treaty by states parties. In such cases, this body also is considered the only authorized organization that can deal with interpretation of the treaty.

Linking this with human rights matters, there is an important point that arises from the establishment of special bodies by treaties. These specialized organizations often focus on related human rights matters that are subject to the convention that instituted the body. Particularly in the case of treaties involving human rights matters, it is worth noting that it is not enough that states parties sign or ratify these treaties; they are also required to act so as to show a real intent to treat them as law. Moreover, states parties are required to take all necessary steps to ensure the application of human rights in the same way as other legal obligations.<sup>201</sup>

Whatever problems a convention may face, it still performs an important role in ensuring recognition of the importance, in this case of health matters, at both national and international level. Because of their international obligations under conventions that are concerned with health care, states are required to take positive action, such as enacting new law or at least notifying other states in case of the spread of disease.

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parties so intended. Available on line at [http://untreaty.un.org/ilc/texts/instruments/english/conventions/1\\_1\\_1969.pdf](http://untreaty.un.org/ilc/texts/instruments/english/conventions/1_1_1969.pdf) accessed 07/11/2012

<sup>198</sup>R. Gardiner, "Treaties and Treaty Materials: Role, Relevance and Accessibility," *The International and Comparative Law Quarterly* 46, no. 3 (1997). 652

<sup>199</sup>Example of this situation can be found in the cases that were reviewed by the European Court of Human Rights such as *D v the United Kingdom* where the Court relied on Art 3 of the European Convention to decide whether or not D's life was threatened or in danger if the immigration authorities departed him.

<sup>200</sup>E. Brems, "Indirect Protection of Social Rights by the European Court of Human Rights," *Exploring Social Rights. Between Theory and Practice*. (2007). 139-50

<sup>201</sup>General comment no 14

Even though there is a still uncertainty about the status of the right to health care as a human right, it can be seen as derivative from international conventions more than any other source of law. However, such conventions need to be ratified by the competent authority in the states parties in order to be implemented by them, so if this procedure has not been undertaken the state's authorities cannot be forced by national or international organisations to implement such a treaty.<sup>202</sup> Here, it is also important to note that if a state signs a treaty but has not yet ratified it, this does not allow it to act against its obligations in light of that treaty. In accordance with article 18, signatory's parties are required to show their good faith in relation to the subject of the international agreement.<sup>203</sup> Although the Universal Declaration of Human Rights (UDHR) is a non-binding convention, it played a significant role in generating serious legal discussion of the right to health care internationally. In article (25), the Declaration states that:

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, and housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. 2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.<sup>204</sup>

Focusing on the UDHR does not mean that the UN charter or the WHO constitution is neglected in this discussion. In fact, they played a fundamentally important role in influencing the drafters of the UDHR. The adoption of the UDHR itself came as a result of the implementation of the Charter of the United Nations, particularly article 1,<sup>205</sup> and the WHO representatives played a fundamental role in the articulation of all articles relevant to health, specifically article 25. More importantly, concentration on the UDHR results from its position as part of an international Bill of Human Rights. Thus, Article 25 of the UDHR was rephrased in a binding treaty in the ICESCR which many international lawyers such as

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<sup>202</sup>Aust, *Modern Treaty Law and Practice*. 106-7

<sup>203</sup>Dixon, *Textbook on International Law*. 65

<sup>204</sup>Universal Declaration of Human Rights 1948 available at <http://www.unhcr.ch/udhr/lang/eng.pdf>

<sup>205</sup> Charter of the United Nations, Article 1 paragraph 3, accessed on 26/11/2010 at <http://www.un.org/en/documents/charter/chapter1.shtml>

Jamar and Leary<sup>206</sup> consider to be the starting point of binding international human rights obligations.

In summary, and despite the different language adopted in the various relevant treaties, the right to health care proposed here, which encompasses these commitments, has the practical status of an international obligation requiring the international community to work together to ensure the provision of appropriate healthcare (including preventive programmes) for all. In other words, vindication of the proposed right to health care is a key issue for nation states and for the international community as a whole. Thus, the international community is required to take health care seriously and try to find a way to make it clear, in terms of both definition and content. It should be obvious that the obligation on the international community to adopt a clear definition or legal framework for recognition and vindication of a right to health care is not only essential for the purposes of this discussion, but for international society itself. Vindicating the right to health care is a major challenge for states and the international community. For example, the United Nations Millennium Declaration encompassed 8 goals. Half of these 8 goals are linked directly to health and the others are indirectly related to health.<sup>207</sup> Manifestly, this requires the international community and member states to pay specific attention to the proposed right to health care.<sup>208</sup> It is also important to emphasize that each state is required to apply its international obligations without delay,<sup>209</sup>

### 2.2.2 General Principles of Law

Another formal source of international law was stated by article (38) to be general principles of law. According to article 38, general principles can be used by the International Court. These principles are defined as “the general principles of law recognized by civilized nations.”<sup>210</sup> Although this has generated considerable debate among

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<sup>206</sup>See Jamar, "International Human Right to Health." 22, also Leary, "The Right to Health in International Human Rights Law."

<sup>207</sup>WHO. Health and Millennium Development Goals. 2005. Online at [http://www.who.int/mdg/publications/MDG\\_Report\\_08\\_2005.pdf](http://www.who.int/mdg/publications/MDG_Report_08_2005.pdf) accessed 14/08/2007 see also D.R. Gwatkin, "How Much Would Poor People Gain from Faster Progress Towards the Millennium Development Goals for Health?," *The Lancet* 365, no. 9461 (2005). 813–17

<sup>208</sup>United Nations, General Assembly United Nations Millennium Declaration. A/RES/55/2. 18/September 2000 available online at <http://www.un.org/millennium/declaration/ares552e.pdf> last seen on 24/03/2010

<sup>209</sup>R. M. M. Wallace, *International Law* (London: Sweet & Maxwell, 2002). 37

<sup>210</sup>Statute of International Court of Justice .Art38. <http://www.icj-cij.org/documents/index.php?p1=4&p2=2&p3=0> accessed on 29/04/2012

international lawyers,<sup>211</sup> discussion of this debate is not relevant here. Rather, the focus will be on the influence of general principles of law on human rights.

It is important, therefore, to explore the nature of general principles and how these principles come to be a source of international law. This has been subject of debate by legal scholars, whose answers can be divided into two groups. The first group focuses on general principles of national law. On this view, general principles of law are only those rules generated and recognized in domestic law by civilized states.<sup>212</sup> For the second group, in addition to the general principles of domestic law, there are general principles of international law which are applied in the international sphere.<sup>213</sup> A good example of these principles is 'non-interference in the affairs of other states' and 'the exclusiveness of a state's jurisdiction within its own territory'.<sup>214</sup> According to Maki, a general principle of law is "[a] safety valve to be applied by courts only when no applicable international convention or custom can be found".<sup>215</sup>

In the legal sphere, it is important to note that this distinction between national and international general principles is not really significant.<sup>216</sup> What is fundamental about these principles, as will be explained below, is that they have been accepted by all legal systems and most importantly they are appropriate and reasonable for the cases in which they are applied. Whether general principles of international law were created in domestic law or they are purely formed in international law, the most important thing is that they can play a fundamental role in the implementation of human rights.

In terms of the right to health care, as with human rights in general, general principles of law - namely participation, non-discrimination, and equity - are not only indications that should inform how this right is provided or applied; they are also general norms which must be supported in law. In other words, they are legal rules and violation of them means

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<sup>211</sup> See for example, Malcolm Shaw, *International Law*, 6th ed. (Cambridge University Press, 2008), 99

<sup>212</sup> Tim, "Sourcebook on Public International Law." 85 see also Shaw, *International Law*. 99 and L.J. Maki, "General Principles of Human Rights Law Recognized by All Nations: Freedom from Arbitrary Arrest and Detention," *Cal. W. Int'l LJ* 10(1980). 274-276

<sup>213</sup> Hugh Thirlway, "The Sources of International Law," in *International Law*, ed. Malcolm D. Evans (Oxford University press, 2010).109

<sup>214</sup> A. Cassese, "International Law," (Oxford University Press, Oxford, 2005). 188

<sup>215</sup> Maki, "General Principles of Human Rights Law Recognized by All Nations: Freedom from Arbitrary Arrest and Detention." 274

<sup>216</sup> T. Hillier, "Sourcebook on Public International Law," *Recherche* 67(1998). 86

violation of the relevant right.<sup>217</sup> In General Comment no 14, the International Commission on Economic, Social, and Cultural Rights (CESCR) required states to take these principles into account when they intend to apply the right to health care.<sup>218</sup> McLean argues that providing health care services without taking these elements into account results in injustice.<sup>219</sup>

In sum, it has been explicitly explained that general principles of law are separate and independent formal sources of law.<sup>220</sup> However; they have been used by the courts as indirect sources. With a broad understanding of general principles of law, these principles could and should play a fundamental role in the clarification and establishment of human rights, and specifically the right to health care. At both national and international levels, courts can use this source widely when making judgements about what the right to health care should be and how it should be applied. If courts did so, it would be possible to judge different states` policies and actions in this respect with more clarity. This also would fill the gap that might have been left by treaties and their interpretation by governments. In addition, they may assist considerably in the development of certain areas of the right, such as definition, scope, and the responsibility of states.

### **2.2.3 Judicial Decisions**

Although judicial decisions form a subsidiary source, they can play a fundamental role in the clarification of international norms. The International Court of Justice (ICJ) especially has considerable weight in the international community, which makes its decisions significant in creating new law. Some jurists, such as Fitzmaurice, argue that decisions of international courts, and in particular the ICJ, should be regarded as a formal source of international rules.<sup>221</sup>

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<sup>217</sup> General Comment 14, para 14 see also Sheila McLean and also J. Sellin, "Justiciability of the Right to Health–Access to Medicines the South African and Indian Experience," *None* (2009). 448

<sup>218</sup> Economic and Social Council. 2000. General comment No 14. available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G00/439/34/PDF/G0043934.pdf?OpenElement> accessed in 20/04/12

<sup>219</sup> Laura Williamson Sheila McLean, Brain Devlin and Audrey Blair, "Ethico-Legal Decision-Making in Healthcare," (Glasgow: University of Glasgow, 2004). 23-36

<sup>220</sup> Shaw, *International Law.*, 99

<sup>221</sup> Brownlie, *Principle of Public International Law.* 5

However, the decisions of the International Court obligate only the parties in the dispute, according to Art.59<sup>222</sup> of the Court Statute. Nonetheless, there is general acknowledgement that decisions of international courts, and in particular the ICJ, have played a significant role in the contemporary development of the law.<sup>223</sup> Decisions of the ICJ, or even its advisory opinions in cases such as *North Sea Continental Shelf* in 1969,<sup>224</sup> Nicaragua,<sup>225</sup> *Libya v Tunisia*,<sup>226</sup> and many others, have had a huge influence on public international law. Although the influence of these decisions is limited by the terms of Article 59 of the Court Statute, they are still respected by members of the international community. In line with Article 59, the Court has full powers to examine each case independently, without being obliged to follow precedent.<sup>227</sup>

The ICJ has not yet adjudicated specifically on the proposed right to health care, but its Statute – particularly in article 38<sup>228</sup> - paves the way for the acceptance that such decisions can be seen as a source of law at the international level, although that source is a subsidiary and not a primary source of the international rules.<sup>229</sup> Pragmatically, it must be said that regional courts, such as the Inter-American Court and the European Court of Human Rights, have been more influential in terms of human rights, including the right to health

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<sup>222</sup>Due to the article 59 of the Statute of ICJ the decision of the Court has no binding on other states or on other cases. It has binding force only on disputed parties and for only such particular case.

<sup>223</sup>S. R. S. Bedi, *The Development of Human Rights Law by the Judges of the International Court of Justice*, vol. 10 (Hart Pub, 2007). See also G. Zyberi, "The Humanitarian Face of the International Court of Justice: Its Contribution to Interpreting and Developing International Human Rights and Humanitarian Law Rules and Principles," *Utrecht University* (2008).

<sup>224</sup>International Court of Justice. *North Sea continental shelf cases*. 1969. available online at <http://www.icj-cij.org/docket/files/52/5561.pdf> accessed 11/03/2007

<sup>225</sup>International Court of Justice. *Case concerning military and paramilitary activities in and against Nicaragua*. 1986. available online at <http://www.icj-cij.org/docket/files/70/6503.pdf> accessed 11/03/2007

<sup>226</sup>International Court of Justice. *Case concerning continental shelf Libya / Tunisia*. 1981. available online at <http://www.icj-cij.org/docket/files/63/9501.pdf> accessed 11/03/2007

<sup>227</sup>J. G. Starke, *Introduction to International Law* (London: Butterworths, 1989). 46-47

<sup>228</sup> Article 38 states that "1. The Court, whose function is to decide in accordance with international law such disputes as are submitted to it, shall apply: a. international conventions, whether general or particular, establishing rules expressly recognized by the contesting states; b. international custom, as evidence of a general practice accepted as law; c. the general principles of law recognized by civilized nations;

d. subject to the provisions of Article 59, judicial decisions and the teachings of the most highly qualified publicists of the various nations, as subsidiary means for the determination of rules of law.

2. This provision shall not prejudice the power of the Court to decide a case *ex aequo et bono*, if the parties agree thereto.

<sup>229</sup>Cassese, "International Law." 188

care, than the ICJ to date.<sup>230</sup> This could be related to their competencies. There are several differences between the ICJ Statute and the conventions that established regional courts. While the ICJ is designed to adjudicate on disputes between states, and only with the consent of the other state or states involved in the conflict,<sup>231</sup> regional courts can hear claims from both individuals and states.

The stance of regional courts - specifically the European Court of Human Rights and the Inter-American Court - on the right to health care is partly similar, in that both courts have protected the right to health care as an aspect of the right to life but each court has followed different methods to reach this result. In the case of the European Court of Human Rights, for example, this result was reached by implementing the standard of ‘exceptional circumstances’ which applied merely when a victim would lose his life if his right to health care was not protected, such as was the situation in *D v United Kingdom*<sup>232</sup> (but not in *N v United Kingdom*<sup>233</sup> as will be seen in chapter four.<sup>234</sup>) In the Inter-American Court on the other hand, it appears that the judges took a wider view, basing their decisions on the standard of ‘dignified life’ which means there might be a violation even when a person was not likely to die, requiring the state to provide food, medicine and medical care.<sup>235</sup>

While this linkage between the right to life and right to health care is a very important step forward in bridging the enforcement gap between negative and positive rights, the question still requiring to be answered is that, if right to health care is a human right in terms of international human rights law, why courts and especially international courts need to view it primarily as an aspect of other human rights, such as the right to life. Indirect protection of health care might also reflect that there are suspicions about the status of health care as

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<sup>230</sup> In European Court of Human Rights, the example is *D v United Kingdom*, and Inter-American Court of Human Rights see these cases *Yakye Axa Indigenous Community v. Paraguay*, *Sawhoyamaxa Indigenous Community v. Paraguay* and *Ximenes-Lopes v. Brazil*.

<sup>231</sup> Article 34 of Statute of the Court states that “1. Only states may be parties in cases before the Court. 2. The Court, subject to and in conformity with its Rules, may request of public international organizations information relevant to cases before it, and shall receive such information presented by such organizations on their own initiative. 3. Whenever the construction of the constituent instrument of a public international organization or of an international convention adopted thereunder is in question in a case before the Court, the Registrar shall so notify the public international organization concerned and shall communicate to it copies of all the written proceedings.”

<sup>232</sup> *D v United Kingdom* - 42 BMLR 149

<sup>233</sup> *N v United Kingdom*, (App no 26565/05), (2008) 25 BHRC 258

<sup>234</sup> Good example of this is *D v the United Kingdom* 2.5.1997 details in the England Chapter

<sup>235</sup> S. Keener and J. Vasquez, "A Life Worth Living: Enforcement of the Right to Health through the Right to Life in the Inter-American Court of Human Rights"[2008-2009]," *Colum. Hum. Rts. L. Rev* 40.595-598

a human right. By using the available legal instruments in national and international law, particularly the constitutional rights included in the constitutions of the Member States, the Inter-American Court also was indirectly able to determine the legal status of the right to health care<sup>236</sup> since the constitutions in Latin American states declare the right to health care to be a constitutional right for every citizen,<sup>237</sup> although these constitutions use different terms, such as the 'right to medical care', the 'right to health protection', the 'right to health' or even the right to 'health services' and 'medical services'. Although they do not use the phrase "the right to health care", this is in fact what they are referring to; that is, the right of individuals to gain health care services and the obligation of the state to provide such services to an acceptable standard, which is equivalent to the right to health care as proposed in this thesis.

Although the decisions of these courts presented the right to health care in a positive light, they did not attempt to interpret what such a right should include, nor what it means in practical terms, nor were they critical of the confusing language that it has been argued here has caused problems for realization of the right. Rather, it seems that the courts were only interested in using these conventions and other available legal materials to emphasize the existence of a human right to health care, however described.

Most importantly, the justiciability of the right to health care is emphasized by the decisions of these regional courts. Such decisions can be used to refute the arguments of those who do not accept that the right to health care is a justiciable right. This development can also be argued to demonstrate that the existence of a right to health care is no longer subject to political or governmental whim. It is a legal issue, allowing individuals to challenge the government if a state fails to provide it. Moreover, individuals' claims are not restricted to domestic courts; rather individuals are allowed to use international institutions, including regional and international courts, in appropriate circumstances.

To conclude, regional international courts have played an essential role in the development and recognition of the proposed right to health care. Even if decisions have relied on the right to life to elucidate healthcare claims, their decisions have built a legal foundation that can be used to demonstrate the legal status of the right itself. These decisions have had two

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<sup>236</sup>Tinta, "Justiciability of Economic, Social, and Cultural Rights in the Inter-American System of Protection of Human Rights: Beyond Traditional Paradigms and Notions."

<sup>237</sup>Hans V Hogerzeil. 2006. Is access to essential medicines as part of the fulfilment of the right to health enforceable through the courts?

important consequences. First, they have established that the right to health care can be, as with other rights, a justiciable right, implying that socioeconomic rights are the same as political and civil rights in terms of judicial protection. Second, the decisions of these courts have also established that judges can evaluate governmental health policy. They can interpret or create a suitable definition that makes the recognition of a right to health care more reasonable, practicable, and - most importantly - achievable. Therefore, courts should be encouraged to use their authority to discuss health care matters in ways that compel states to recognize and accept their responsibilities in this respect. This recommendation is also true for international organizations, which will be the subject of a later subsection.

#### 2.2.4 Academic Writings

Art. 38 (1) (d) describes another subsidiary source of international law.<sup>238</sup> It is important to note that legal departments of governments usually rely on writings of academics to provide legal advice to their governments. Of course, they do not use just any textbook or publication on international law, preferring those that support their state's view.<sup>239</sup> Other issues might be taken into account when they choose which academic to rely on; such as the time of writing, the political convictions of the writer, and his/her nationality.<sup>240</sup>

Although the writings of academics have influenced state practice, it seems that the International Court has not directly shown any interest in using them when it makes its decisions. The judgments of the ICJ usually include separate and dissenting opinions of the Court's Judges themselves who are in fact part of the most highly qualified academic commentators of the various nations.<sup>241</sup> Interestingly, support for recognition of the right to health care is stronger in academic writings than in other sources. For instance, a large number of USA academic writers believe that the right to health care is a legal right even although no ratified international treaty actually contains such a legal right.<sup>242</sup> Furthermore,

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<sup>238</sup> ICJ. The Statute of the International Court of Justice. Article 38 visit <http://www.icj-cij.org/documents/index.php?p1=4&p2=2&p3=0> accessed 19/03/2007

<sup>239</sup> Shaw, *International Law*. 113 see also, in the evidence of custom the role of the opinions of official legal advisers, Maclean and Tutors, *Public International Law Textbook*. 11 and T. Hillier and Z. Yang, *Principles of Public International Law* (Cavendish, 1999). 31-32

<sup>240</sup> Dixon, *Textbook on International Law*. 45

<sup>241</sup> See L.F. Damrosch, *International Law: Cases and Materials* (Thomson/West, 2009). 139-42

<sup>242</sup> See for example Yamin, "The Right to Health under International Law and Its Relevance to the United States." Also PEREIRA, "Live and Let Live: Healthcare Is a Fundamental Human Right." And Leary, "The Right to Health in International Human Rights Law." See also Kinney, "Recognition of the International Human Right to Health and Health Care in the United States."

it has been noted that the importance of academic writings has not been clearly recognised by the international judicial institutions in their judgments, particularly the ICJ. Arguably, however, the writings of academics could be appropriately used where regulation is ambiguous and uncertain, and could be very important in elucidating the content and scope of the proposed right. The importance of the writing of academics arises also from its contribution to customary law. There is agreement that this has played a fundamental role in establishing state practice.<sup>243</sup> Starke, for example, has argued that the work of academics is not only declaratory of the existence of customary rule, but it also can establish that custom.<sup>244</sup>

To conclude, in the absence of international customary law or direct judicial decisions on the right to health care, the writings of academics may make an important contribution to bolstering the legal status of the proposed right to health care for all.

### **2.2.5 Resolutions of International Organizations**

Although, the list in article 38 does not regard the resolutions of international institutions as a source of international law, nor even as material or evidential sources, these resolutions have started to play an essential role in both international relations and law. Both these resolutions and court decisions can accelerate the formation of customary law. The importance of these resolutions can be clearly seen in the main UN body and other specialized international organizations; for this discussion, most importantly, the World Health Organization. Starke has suggested that the resolutions of international organizations may reflect international law in several ways.<sup>245</sup> For instance, in the Texaco case<sup>246</sup>, the arbitrator, Dupuy, utilised two General Assembly resolutions: GAR 1803 (1962) on the Permanent Sovereignty over Natural Resources and GAR 3281 (1974), the Charter of Economic Rights and Duties of States.<sup>247</sup> The contribution of international resolutions as a source of international law is divided into two sorts. In the following sections, these will be explored, as they have an impact on the development of human rights.

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<sup>243</sup>Starke, *Introduction to International Law*. 50

<sup>244</sup>Ibid. 50-51

<sup>245</sup> He explained these ways with more details in his book *Introduction to International Law*.

<sup>246</sup> *Texaco Overseas Petroleum Co v Libya R. J. Dupuy, Texaco Overseas Petroleum Company and California Asiatic Oil Company V. The Government of the Libyan Arab Republic: International Arbitration; Preliminary Award and Award on the Merits* (1977).

<sup>247</sup>For this and other examples see Maclean and Tutors, *Public International Law Textbook*.. 23-24

### 2.2.5.1 Resolutions of the General Assembly (GA)

Reading through the fourth chapter of the charter of the United Nations, it is clear that the general rule is that these resolutions are not binding. Because of this, Hillier and Yang have questioned whether they can create law. Therefore, they argue that resolutions can only be used as evidence of state practice but that the only GA resolutions that are binding are those related to financial or budgetary decisions.<sup>248</sup> Shaw argues, as do many others including Hillier and Yang,<sup>249</sup> that the General Assembly resolutions have played a fundamental role in proving that there is international customary law.<sup>250</sup> The role of General Assembly resolutions in establishing, or at least declaring, customary law has also been affirmed by the International Court of Justice. In its Advisory Opinion on the Legality of the Threat or Use of Nuclear Weapons, the Court stated that:

The Court notes that General Assembly resolutions, even if they are not binding, may sometimes have normative value. They can, in certain circumstances, provide evidence important for establishing the existence of a rule or the emergence of an *opinio juris*. To establish whether this is true of a General Assembly resolution, it is also necessary to look at its content and the conditions of its adoption; it is also necessary to see whether an *opinio juris* exists as to its normative character. Or a series of resolutions may show the gradual evolution of the *opinio juris* required for the establishment of a new rule.<sup>251</sup>

In addition, international lawyers believe that resolutions of the General Assembly can sometimes be binding, depending on the scope of the resolution and what purpose it is designed to serve.<sup>252</sup> As mentioned above, for instance, a good example of this is budgetary decisions. For this reason, RGA (Resolutions of the General Assembly) are divided into two categories. First, the resolutions that deals with international affairs in general. Such resolutions are more likely to be recommendations, which mean that they are not binding. Second, resolutions related to internal affairs of the institution such as resolutions on budget, on the admittance of new states, and on the appointment of judges to the ICJ. Such resolutions are all officially binding. Furthermore, these resolutions

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<sup>248</sup>Hillier and Yang, *Principles of Public International Law*. 33-34

<sup>249</sup>Ibid. 36

<sup>250</sup>Shaw, *International Law*. 108-111

<sup>251</sup>International Court of Justice. Reports of Judgments, Advisory opinions and orders, Legality of the use by a state of nuclear weapons in armed conflict. Advisory opinion of 8 July 1996. available online at <http://www.icj-cij.org/docket/files/93/7407.pdf>

<sup>252</sup>Dixon, *Textbook on International Law*. 48

sometimes have influence not only in member states but also on non-members. Thus, non-member states are required to respect them.<sup>253</sup>

To return to the first category, although these resolutions are not binding, legal scholars have realized that they play an essential role in the development of international law.<sup>254</sup> In particular, it seems that resolutions of the General Assembly are used by new states as instruments that can clarify their views on international rules. Therefore, resolutions of the General Assembly often lead to the adoption of a declaration or an agreement. In 1974, the RGA on the Charter of Economic Rights and Duties, for example, began the process towards the adoption of an international agreement on the same subject matter.<sup>255</sup>

It could be said that these resolutions have given the General Assembly a good opportunity to build up human rights issues. Thus, the UN, specifically the General Assembly, has used the legal technique of 'unanimous vote' or 'consensus' to avoid lengthy negotiation or rejection by states parties. In this situation, the General Assembly relies on the International Law Commission to make drafts of certain conventions that are usually submitted to members of the GA and are generally accepted unless particular state express an opt out.<sup>256</sup> This technique was used in most of the human rights treaties such as the International Bill of Human Rights which were adopted by the Resolutions of the General Assembly.<sup>257</sup>

The above statement indicates that the international community prefers to use the 'unanimous vote' or 'consensus' technique in the General Assembly in order to pass human rights agreements with no rejection. In the view of some writers, the extent to which the RGA is binding will depend on its subject matter.<sup>258</sup> Thus, if the subject, for instance, is related to a human rights matter or international peace and security, it will be

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<sup>253</sup>Ibid.46

<sup>254</sup>T. Hillier, *Sourcebook on Public International Law* (Routledge Cavendish, 1998).33-35

<sup>255</sup>Starke, *Introduction to International Law*. 52- 53

<sup>256</sup> See Hillier, *Sourcebook on Public International Law*. 34-36, C. C. Joyner, "Un General Assembly Resolutions and International Law: Rethinking the Contemporary Dynamics of Norm-Creation," *Cal. W. Int'l LJ* 11(1981). 456, L. B. Sohn, "Generally Accepted International Rules," *Wash. L. Rev.* 61(1986).1074

<sup>257</sup>Universal Declaration of Human Rights, International Convention on Political and Civil Rights and International Convention on Economic, Social and Cultural Rights.

<sup>258</sup>Dixon, *Textbook on International Law*. 46

binding whether it was subject to internal or external resolution. The point is that the latter resolutions cannot be seen only as recommendations; they can be binding.<sup>259</sup>

### 2.2.5.2 Other International Bodies

In the UN, and in regional areas, there are international organisations that can pass an official resolution in respect of their members. In the UN, a decision of the Security Council taken under section VII of the charter, is binding.<sup>260</sup> For the purposes of this discussion, it is important to explore the nature of resolutions which are taken by the WHO. Looking closely at the constitution of the WHO, in particular articles 19 and 20, it is clear that the Health Assembly has been authorized to adopt conventions or regulations in respect to health matters.<sup>261</sup> For example, a convention adopted by the Health Assembly will come into force for each member state when it is accepted. Furthermore, members are required to take steps within a maximum period of eighteen months to show compliance with the agreement. This condition is not usually included in other international agreements. In fact, other agreements are often implemented under the general rule that states are free to choose when to ratify.

To summarize, sources of law, specifically international law, appear to have treated health care theoretically as a human right but in reality, and as explained above, the vagueness of the language used in these international sources made the international community hesitates in considering health care as a full human right. Nonetheless, as will be discussed in later chapters, the 'right' has taken some shape; it is more than merely aspirational. Thus, the proposed right to health care is arguably supported, albeit in an indirect way, by sources such as international treaties, international customary law, decisions of international courts and resolutions of international institutions. Therefore, it can be argued that the substance of the proposed right is acknowledged in these sources even if they donot formally recognise it as a human right.

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<sup>259</sup>Damrosch, *International Law: Cases and Materials*.146

<sup>260</sup>Dixon, *Textbook on International Law*. 49, P. Sands, P. Klein, and D.W. Bowett, *Bowett's Law of International Institutions* (2009). 43-51

<sup>261</sup>Constitution of the WHO. Visit:[http://www.who.int/governance/eb/who\\_constitution\\_en.pdf](http://www.who.int/governance/eb/who_constitution_en.pdf) accessed 06/11/2012

## 2.2.6 Other sources of International Law

There are other sources of international law, such as international customary law and soft law, which have not yet played a fundamental role in regard to the right to health care, although they may do so in the future.

### 2.2.6.1 International Customary Law

International customary law has not yet played any crucial role concerning health care as a human right although this is considered as the main source in international law. However, this does not mean that customary law has nothing to say on the right to health care. There is a strong belief that the ICESCR, at least as part of the UDHR, should now be seen as international customary law.<sup>262</sup>

At the present time, customary law might be able to give a rational interpretation of the meaning of the right to health care and its content. As is well known, customary law assumes the existence of two elements - state practice, which must be coupled with the psychological element which means that states act under a customary rule because it is a binding rule.<sup>263</sup> In terms of the proposed right to health care, customary law can explain what this means in practice. For example, each state has a ministry of health which is responsible for providing health care services. Clarification of the nature and content of this proposed right would allow determination of the state's responsibilities in this respect. In the future, the role of customary law might be more important in explaining the nature of the proposed right and its limitations.

In relation to sources of international law, there is an additional important source that needs to be explored. This source is "soft" law. Given its importance, this thesis will examine it in a separate subsection to explain its meaning and influence on governments and the judiciary in practice. Although soft law is not legally binding, it plays a fundamental role in generating new customary law.<sup>264</sup> However, from what has been argued here, the debate about the legal status of the proposed right to health care, as with

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<sup>262</sup>Leary, "The Right to Health in International Human Rights Law."32

<sup>263</sup> Further discussion about the concept of this element could be found in many other specific articles such as O. Elias, "The Nature of the Subjective Element in Customary International Law," *The International and Comparative Law Quarterly* 44, no. 3 (1995). 502 and Maclean and Tutors, *Public International Law Textbook.*,

<sup>264</sup>D. Shelton, "International Law and Relative Normativity," *Evans, Malcolm, International Law, Oxford* (2010). 141

other human rights included in the ICESCR, seems to have been clarified; in other words, there are sufficient sources that suggest that it should be recognised as a right.

To conclude this section, it has been proposed that sources of international law seem to support the legal status of the right to health care. However, these sources have caused difficulties in the implementation of this right because of the vagueness of the terms used to describe it. Any legal discourse, and all international and national health arguments about health care as a human right, begin by discussing these sources and what the right to health care means. These sources, and specifically the resolutions of international organizations, can play an important role in establishing the shape of the proposed right to health care.

### **2.3 Soft Law and the Right to Health Care**

Because the right to health care is (albeit sometimes indirectly) recognized by declaration and resolution, soft law can and should play an essential role in the manifestation of its legal status. The Universal Declaration of Human Rights and the International Convention of Economic, Social, and Cultural Rights provide the basis for the proposed right to health care, even if the language used differs. This raises the question as to whether or not these instruments can persuade states to respect the right. In other words, how can soft law as a source of international law in contemporary international relations influence the right to health care, particularly in practice?

The answer to this question requires discussion of three issues. The first is to identify what is meant by soft law. The second is to identify the importance of soft law. The third and most important question is how soft law can affect the right to health care and what consequences will flow from this. Malcolm says that soft law is “a convenient description for a variety of non-legally binding instruments used in contemporary international relations by states and international organizations.”<sup>265</sup> Thus, instruments such as declarations and resolutions of the UN General Assembly,<sup>266</sup> conference declarations, guidelines, and recommendations would qualify as soft law.<sup>267</sup>

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<sup>265</sup>ibid. 142

<sup>266</sup>Examples of these resolutions are Universal Declaration of Human rights 1948 and the ICCPR and the ICESCR.

<sup>267</sup>For reference to definition see Dixon, *Textbook on International Law*. 47

To have a clear understanding of what soft law is, it is important to contrast it with hard law, which is always binding. This does not mean that soft law is not law. As has been explained by Boyle, “they may be soft, but they are still law.”<sup>268</sup> This does not always mean that there is a significant difference between soft law and treaties. According to Judge Baxter, not every treaty imposes real obligations on the parties; in this sense, some treaties are soft law. In the North Sea Continental Shelf Case, the ICJ made this point, stating that a fundamental condition that is required before a treaty can be considered as law-making is that it should be so drafted as to be ‘potentially normative’ in character.<sup>269</sup> But Chinkin seems have another view: he argues that there is a wide diversity between the two instruments. On cursory examination, one can see that these diversities can arise from several sources, such as language, subject matter, participants, addressees, purposes, follow-up and monitoring procedures. Moreover, these differences are associated with the inherent disagreement about the concept of soft law.<sup>270</sup>

As a legal instrument, it is important to note that soft law is useful because of its flexibility and the speed with which it can be made. International organizations prefer to utilize it to avoid lengthy negotiations between member States. In addition, governments also sometimes employ soft law to shorten the duration required by their constitutions for ratification of a treaty. In other words, by using soft law states can avoid the national treaty ratification process.

Consequently, soft law or a so-called non-binding treaty can have a creative impact on international law and its subjects, such as States and international organizations. These effects are of different types due to the sort of sources of international law that are affected by soft law. In respect of its special nature, the right to health care requires the detailed rules and acceptable standards that soft law can provide. Soft law is often important in setting standards or encouraging states parties to achieve full realization of rights and implementing their obligations.<sup>271</sup> The benefits of regulating health care issues in this way are that the detailed rules can easily be changed or strengthened as understanding of the right to health care develops or as political priorities change. At the same time, it can bring

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<sup>268</sup>Shelton, "International Law and Relative Normativity." 151

<sup>269</sup>ICJ.Judgment of North Sea Continental Shelf Cases. 20/02/1969. Online at <http://www.icj-cij.org/docket/files/52/5561.pdf> accessed 03/08/2010

<sup>270</sup>C.M. Chinkin, "The Challenge of Soft Law: Development and Change in International Law," *International and Comparative Law Quarterly* 38, no. 04 (1989).850

<sup>271</sup>A.T. Guzman and T.L. Meyer, "International Soft Law," *Journal of Legal Analysis* 2, no. 1 (2010).

flexibility in dealing with emergency cases and questions about the availability of resources. Before discussing the influence of soft law on other international law instruments such as treaty, customary law and general principles of law, it is important to note that, in terms of human rights law, soft law is a main legal source which the international community usually uses for respecting human rights treaties, including non-binding treaties such as the UDHR. In many cases, soft law aims to highlight the legal status of the treaty in general without creating a particular obligation. In accordance with the Vienna Convention on the Law of Treaties, having international agreement requires only that the agreement is in written form and subject to international law, which satisfies the definition of soft law.

### **2.3.1.1 The Role of Soft law as a Source of International Law**

As explained above, states and international organizations may use soft law to avoid long-term negotiations or cut down the constitutional procedures that governments require to follow to ratify an agreement. In Chinkin's view, the use of soft law aims to create a legal ground for cooperation between states.<sup>272</sup> But it does not deal with the enforcement of the agreement. In this sense, it is important to remember that the enforcement of the agreement is subject to the conclusion of an agreement.<sup>273</sup> Moreover, states often utilize soft law to make their obligations look flexible which allows them to interpret these obligations in a way that suits them. Chinkin has stated that "Soft law is well suited for the specification of interests and values but does not provide the required precision for such matters as the passing of title or of risk"<sup>274</sup>. This view cannot be accepted completely, especially with regard to the language of rights. For example, there are obvious international legal instruments initially derived from soft law, such as the Universal Declaration of Human Rights 1948 (UDHR), the Rio Declaration on Environment and Development 1992<sup>275</sup> and the Declaration on the Rights of Indigenous Peoples 2007<sup>276</sup> and many more.<sup>277</sup> At this

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<sup>272</sup> A. Boyle, "Soft Law in International Law-Making," in *International Law*, ed. Malcolm D. Evans (Oxford University Press, 2010). 125, Guzman and Meyer, "International Soft Law." 171, Chinkin, "The Challenge of Soft Law: Development and Change in International Law." 861

<sup>273</sup> Guzman and Meyer, "International Soft Law". 171 Chinkin, "The Challenge of Soft Law: Development and Change in International Law." 861

<sup>274</sup> Chinkin, "The Challenge of Soft Law: Development and Change in International Law." 861

<sup>275</sup> United Nations, General Assembly, Report on the United Nations Conference on Environment and Development, A/CONF.151/26 (Vol. I), 12 August 1992, accessed date 04/08/2012 at <http://www.un.org/documents/ga/conf151/aconf15126-1annex1.htm>

<sup>276</sup> United Nations, General Assembly, United Nations Declaration on the Rights of Indigenous Peoples, accessed date 04/08/2012, [http://www.un.org/esa/socdev/unpfii/documents/DRIPS\\_en.pdf](http://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf)

stage, it should be clear that soft law has a role to play in terms of the sources of international law. This role is dependent on which source of international law has been affected by soft law, and the influence of soft law on treaties or existing law is different from its effects on customary law or general principles of law.

### 2.3.2 Soft Law and Treaties

It is important to remember that soft law can be formulated in treaty form. In Chinkin's words; a treaty "does not of itself ensure a hard obligation."<sup>278</sup> In international law, a treaty is an agreement that is in writing and subject to international law.<sup>279</sup> Second, in any form, the existence of soft law means that states cannot act as if there is no law at all.

With this in mind, the influence of soft law on treaties can take several forms. First, as pointed out by Hillgenberg, soft law can be used to help states parties understand their obligations by interpreting a treaty.<sup>280</sup> For example, some writers such as John O'Brien regard the Rio Declaration in 1992 as soft law that interpreted vague concepts in the environmental field.<sup>281</sup> It could, therefore, also be useful in clarifying the right to health care and what it should include. The UN or the WHO could utilize soft law to identify and clarify what such a right means and how it can be implemented.

A second role is that soft law can be the first step in a process finally leading to the adoption of a multilateral treaty. A good example of this is the non-binding Universal Declaration of Human Rights. Although the UDHR is a non-binding treaty it was the main reason why the UN General Assembly adopted the ICCPR and the ICESCR in 1966.<sup>282</sup>

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<sup>277</sup> For instance Declaration on Principles of Friendly Relations Among States 1970 available at <http://www.unrol.org/files/3dda1f104.pdf> accessed on 28/09/2012, the United Nations Environment Programme (UNEP)'s 1987 Guidelines on Environmental Impact Assessment, the Food and Agriculture Organisation (FAO)'s Code of Conduct on Responsible Fisheries, available at <ftp://ftp.fao.org/docrep/fao/005/v9878e/v9878e00.pdf>, accessed on 24/09/2012

<sup>278</sup> Chinkin, "The Challenge of Soft Law: Development and Change in International Law." 851

<sup>279</sup> See article 2 a of Vienna Convention on the Law of Treaties 1969, online at [http://untreaty.un.org/ilc/texts/instruments/english/conventions/1\\_1\\_1969.pdf](http://untreaty.un.org/ilc/texts/instruments/english/conventions/1_1_1969.pdf) accessed 03/05/2007

<sup>280</sup> H. Hillgenberg, "A Fresh Look at Soft Law," *European Journal of International Law* 10, no. 3 (1999). 514

<sup>281</sup> John O'Brien, *International Law* (London: Cavendish publishing limited, 2001). 98

### **2.3.2.1 Soft law and general principles of international law**

It has already been mentioned that states can adopt general principles of law that are not derived from national law. Such general principles are often generated by non-binding declarations or resolutions of international organizations. Such norms not only affect judicial decisions that may be taken by courts in the case of conflict, but states are also required to take these principles into account when dealing with human rights issues.

As a matter of law, international courts can always refer to general norms as sources of international law in accordance with article 38(1) (c) of the ICJ Statute, whether these principles were derived from international relations or were borrowed from domestic law. The most important point here is that the Universal Declaration of Human Rights is a famous example of these principles. In fact, it could be said that the Declaration is a collection of principles. Thus, there is a sense of constitutional rules in each article of the Declaration.

General principles might only be applied by the courts when no international convention or custom can be found.<sup>283</sup> It should be clear that even if an international agreement or custom is identified courts are required to apply them in light of these general norms. In other words, courts should not apply an international agreement or custom that is in conflict with general principles, especially those of equity and non-discrimination.

### **2.3.2.2 Soft Law and Custom**

Although soft law includes only soft obligations, there is agreement that soft law instruments result from treaties.<sup>284</sup> Because it is developed from treaties, soft law could be a first step in the creation of new law. The influence of custom on soft law is very important especially in terms of the right to health care.

To return to the relation between soft law and custom, it should be clear that the non-binding character of the resolutions or declarations of international organizations does not mean that they have no legal effect on customary law. Therefore, declarations by states or resolutions of international organizations could be the start of new law, or make changes to

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<sup>283</sup>Maki, "General Principles of Human Rights Law Recognized by All Nations: Freedom from Arbitrary Arrest and Detention." 274

<sup>284</sup>Robert M MacLean, *Textbook Public International Law* (Old Bailey Press, 1997). 25

existing law. This role for soft law requires the consent of states, which is still a fundamental precondition for the development of new law or changes to existing law.

In regard to General Assembly resolutions and whether they can create instant law, although they may not be able to create instant law they can indicate the existence of customary law or a new rule.<sup>285</sup> According to the ICJ, there is no agreement about how much time is needed for consistent, general state practice to mature into customary law.<sup>286</sup> But we may agree with Cheng that to contribute to the creation of customary law, General Assembly resolutions require appropriate wording<sup>287</sup> which has been highlighted in this thesis as one main problem of human rights in general, and specifically the right to health care.

The adoption of non-binding resolutions or declarations can interact with customary law in two ways. First, it can be the first step in the creation of a new customary law. Second, it can change existing law.

### **2.3.2.3 Soft Law and Domestic Legal Systems**

To some extent, it is likely that soft law may have an influence upon the whole legal system.<sup>288</sup> For the purposes of this discussion, the focus will be on the impact of soft law in domestic courts. Sources of international law cannot be directly implemented by national courts until they become national rules by incorporation or transformation into national law. However, soft rules may be implemented by national courts as part of international customary law or evidence as to what the state has accepted. Theoretically, there are two viewpoints in regard to the implementation of human rights law in domestic courts. On the dualist view, in order to apply norms of international law in state territories or invoke them in domestic courts they ought to be transformed into domestic law.<sup>289</sup> But this is not always required, at least in the view of the monists who believe that international law and

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<sup>285</sup>Dixon, *Textbook on International Law*. 48-49

<sup>286</sup>North Sea Continental Shelf Cases,

<sup>287</sup>Shelton, "International Law and Relative Normativity." 154

<sup>288</sup> See in generally L. Sossin and C. Smith, "Hard Choices and Soft Law: Ethical Codes, Policy Guidelines and the Role of the Courts in Regulating Government," *Alberta Law Review* 40(2003). 867-893 also T. Gruchalla-Wesierski, "Framework for Understanding Soft Law, A," *McGill LJ* 30(1984). 37-88

<sup>289</sup>Shaw, *International Law*. 131, Wallace, *International Law*. And also Tim, "Sourcebook on Public International Law."

domestic law are simply the same subject matter.<sup>290</sup> In addition, the fact is that resolving this argument practically depends on the legal system of each state. In the UK, for example, as Dixon explains, courts are authorised only to apply an international treaty when that treaty is transformed by statute into British law, including international human rights law, directly relevant to cases heard before them.<sup>291</sup>

In terms of soft law's influence on domestic legal systems, soft law usually comprises non-binding instruments, such as declarations, guidelines and General Assembly resolutions. Evans states that "The proposition is not that non-binding declarations or resolutions of the General Assembly or any other soft law instrument are law per se, but simply that in appropriate cases such instruments may be evidence of existing law, or formative of the *opinio juris*."<sup>292</sup>

In terms of human rights law, there are several cases that show how national courts have been influenced by soft rules. For example, the Universal Declaration of Human Rights (UDHR), which is considered as soft law by the majority of legal scholars, has been utilized by courts in different ways. In Austria and Tanzania, for example, courts treat the UDHR as customary international norms, while other national courts have used the Declaration as evidence of governmental policy.<sup>293</sup> Most importantly, the legal value of the Declaration can also emerge from references made by countries in their constitutions to the UDHR.<sup>294</sup>

Although there are no cases based directly on soft law in regard to a right to health care, it is likely that soft law has had considerable influence on some relevant cases; especially HIV cases. In these cases, national courts have relied on soft law to highlight the positive obligation of the state to provide appropriate medication and health care to HIV carriers. In South Africa, for instance, the South African Constitutional Court has referred to non-

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<sup>290</sup>This is a view of monists who believe that international and national law are part of the same legal system. See in generally Dixon, *Textbook on International Law*.

<sup>291</sup>*ibid.* 101

<sup>292</sup>Shelton, "International Law and Relative Normativity." 142

<sup>293</sup>H. Hannum, "The Udhr in National and International Law," *Health and Human Rights* (1998). 150-51

<sup>294</sup> Good illustration of this case can be found in most constitutional of African countries such as Angola, South Africa and India

binding sources of international law to establish a right to health care for all people, especially those living with HIV.<sup>295</sup> In his judgment, Justice Yacoob clearly stated that:

The relevant international law can be a guide to interpretation but the weight to be attached to any particular principle or rule of international law will vary. However, where the relevant principle of international law binds South Africa, it may be directly applicable.<sup>296</sup>

Similarly, soft law has been utilized by Southeast Asian countries to address HIV/AIDS in this region. To monitor the health of migrant workers, for example, the Association of South East Asian Nations suggested that the region required adopting a common policy in relation to the integration of HIV prevention programmes as a precondition for any workers that might be employed in construction and infrastructure development contracts bidding and approval.<sup>297</sup> In 2003, the same group of states adopted Recommendations on building HIV Resilience along the ASEAN Highway.<sup>298</sup>

#### **2.3.2.4 Soft Law and General Comments**

In principle, General Comments are not binding, but this does not mean that they have no role to play. In fact, General Comments of the International Commissions (ICPCR or CESCR) have played a fundamental role in what rights mean and how they can be achieved. In other words, they are considered as guidelines and instructions to the international community in regard to human rights. Thus, as non-binding guidelines they were linked to soft law. Therefore, there is agreement that general comments, at least to some extent, can be treated as soft law<sup>299</sup> which for the purposes of this discussion seems an appropriate place to discuss the legal value of the General Comments that have been issued by the International Committee on economic, social and cultural rights, especially on the subject of the right to health care. Since the establishment of the International

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<sup>295</sup> See in generally L. Forman, "Ensuring Reasonable Health: Health Rights, the Judiciary, and South African Hiv/Aids Policy," *The Journal of Law, Medicine & Ethics* 33, no. 4 (2005). 711-724

<sup>296</sup> Constitutional Court of South Africa, *Grootboom v the government of Republic of South Africa*, Case CCT 11/00, see paragraph 26 online at [http://www.lib.utoronto.ca/Diana/TAC\\_case\\_study/Grootboom.pdf](http://www.lib.utoronto.ca/Diana/TAC_case_study/Grootboom.pdf), accessed 21/04/2012

<sup>297</sup> D. Patterson et al., "Use of Soft Law to Address Hiv/Aids in Southeast Asia," *HIV/AIDS policy & law review/Canadian HIV/AIDS Legal Network* 12, no. 2-3 (2007). 18

<sup>298</sup> In general see *ibid.*

<sup>299</sup> As non-binding documents that usually are used as references to explain what exactly certain international obligations or conception meant.

Committee in 1981, the International Committee has issued about twenty one General Comments by 2009.<sup>300</sup>

In terms of the right to health care, it is significant to note that this was discussed directly or indirectly in several of these General Comments. For instance, health care was part of General Comment No 19 which is about the right to social security. Thus, the Committee clearly stressed that health care is the first branch of social security that any state aims to achieve.<sup>301</sup> Another good example is General Comment No 14.<sup>302</sup> In this Comment, the International Committee expressed its position on what might be meant by a right to health care and how it could be implemented in reality. However, its work was influenced strongly by the broader international concept of the right to health rather than the right to health care that this thesis recommends.<sup>303</sup>

Whether these Comments dealt with a right to health or a right to health care, they have answered an important question about the legal status of the right and how states parties should work to implement socioeconomic rights, such as the right to health care. General Comments can play a significant role in clarification and implementation of human rights in terms of both the language of rights and their legal status. They are not only guidelines that states are required to follow but they also have other functions. According to Marsh, General Comments can, at least, have three functions in relation to human rights. As she says:

First, comments can be used to universalize particular recommendations and decisions arrived at through reporting and complaints mechanisms respectively... Second, general comments function as a means of providing authoritative guidance to a broader group of states than would be encompassed by the first two mechanisms (reporting and complaints) independently... Finally, general

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<sup>300</sup> See the list of these General Comments online at <http://www2.ohchr.org/english/bodies/cescr/comments.htm> accessed 13/09/2012

<sup>301</sup> UN. General Comment No 19. 2008, <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G08/403/97/PDF/G0840397.pdf?OpenElement> accessed 21/04/2012

<sup>302</sup> General Comment No 14

<sup>303</sup> In relation to this, see generally General Comments No 5, 6, 7, 12, 18, 19, online at <http://www2.ohchr.org/english/bodies/cescr/comments.htm> accessed 21/04/2012

comments can be used to reinforce the necessary linkages to other international human rights organs and the international legal system as a whole.<sup>304</sup>

In terms of soft law, it is likely that General Comments can be an appropriate basis for the establishment of soft law, and can be a good example of soft law. They are non-binding instruments and moreover they are not treaties. However, states are required to deal with socioeconomic rights in the light of these General Comments; otherwise, the International Committee will consider any state that does not respect these Comments as a violator of such rights.

To summarise, soft law is an important source that could be used to develop human rights, and specifically the proposed right to health care. It can save the time that states may otherwise need to spend on reaching an agreement which also may not come into effect for some considerable time. Most importantly, soft law always respects the will of states. Thus, any changes to existing law or the creation of new law will always require the consent of states. Although soft law has not yet played a clear role as a source of international law, it may be evidence of an existing rule or a state practice that produces customary international law.<sup>305</sup> In terms of the right to health care, soft law has a special position which allows it to be used for specification and clarification of its nature and content..

### **2.3.3 The Influence of International Law on Individual States**

The effect of international law on individual states depends upon the source from which the legal ruling was generated. Once identified, the right to health care would be applicable in international law and the above sources could be used to claim it. As an international legal obligation, states would then be obliged to respect it and undertake steps to demonstrate that respect. Despite the debate about the possibility of implementing the right to health care, most legal writers, such as Mann,<sup>306</sup> Yamin,<sup>307</sup> Jamar,<sup>308</sup> Pereira,<sup>309</sup> and

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<sup>304</sup> Elizabeth Marsh. 2001. General Comments, working paper no (3). A collaboration of the international council of voluntary agencies and the program in refugee and asylum law University of Michigan, on line at [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=294184](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=294184)

<sup>305</sup> I. Seidl-Hohenveldern, *Corporations in and under International Law*, vol. 6 (Cambridge University Press, 1987). 14

<sup>306</sup> J. Mann, "Health and Human Rights: If Not Now, When?," *American Journal of Public Health* 96, no. 11 (2006).

<sup>307</sup> A.E. Yamin, "Will We Take Suffering Seriously? Reflections on What Applying a Human Rights Framework to Health Means and Why We Should Care," *Health and Human Rights* (2008). Also her

Jones<sup>310</sup> consider it to be a human right, whether it is a primary right or not. The nature of economic and social rights has affected the ways in which they are implemented by states. In general, there are three types of effects that follow recognition of a right. First, states have to show commitment to the international obligation even before ratification of the treaty. Second, they must accept the obligations that result from the nature of the right. Third, the obligations derived from the right must be implemented. In other words, unless these obligations are accepted, speaking about human rights will be meaningless. In light of article (11) of the Vienna Convention,<sup>311</sup> this section of the thesis will examine the influence of international law on individual states. In the first subsection, it will illustrate the obligations that may need to be accepted by states parties before they undertake the procedures of ratification. The second subsection will discuss the obligations which are required from the states when they comply with international legal rules, whether such rules derived from treaty or custom. Finally, an explanation of how these obligations should be implemented will be given. In other words, the discussion will focus on the general principles of human rights, which could also be called general obligations of human rights, that are required to vindicate any human right - whatever its nature or category.

### **2.3.3.1 The State's Obligations Before Ratification**

It is important to note that ratification is a legal procedure that belongs especially to treaties. Thus, it is not relevant to other international sources such as customary international law or general principles of law. It should be clear that focusing on treaties does not mean that other sources are not important. Other sources seem less complicated than treaties; however, treaties are a quick way to create international rules - especially international human rights rules. Irrespective of ratification, there are two situations where a treaty could impose an obligation on states parties. First, if there is agreement to accept

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article A.E. Yamin, "Protecting and Promoting the Right to Health in Latin America: Selected Experiences from the Field," *Health and Human Rights* (2000).

<sup>308</sup>Jamar, "International Human Right to Health."

<sup>309</sup>PEREIRA, "Live and Let Live: Healthcare Is a Fundamental Human Right."

<sup>310</sup>See G.E. Jones, "The Right to Health Care and the State," *The Philosophical Quarterly* 33, no. 132 (1983). 280

<sup>311</sup>Article (11) of 1969 Vienna Convention provides: "The consent of a State to be bound by a treaty may be expressed by signature, exchange of instruments constituting a treaty, ratification, acceptance, approval or accession, or by any other means if so agreed." Available at [http://untreaty.un.org/ilc/texts/instruments/english/conventions/1\\_1\\_1969.pdf](http://untreaty.un.org/ilc/texts/instruments/english/conventions/1_1_1969.pdf) accessed 21/04/2012

signature as a formal acceptance of the state's obligation, then that signature establishes consent to be bound by its terms.<sup>312</sup>

Secondly, a signature usually means that the state needs some time or has to implement other procedures to make its final decision in regard to the subject of the treaty. Although the state has a right to choose when it will make its final decision, until then the state must show good faith in relation to its international obligations. Showing good faith means that the state refrains from acts calculated to frustrate the objectives of the treaty. In terms of human rights, this is very important to show that states parties are serious in relation to the achievement of human rights regardless of making their final decision.<sup>313</sup> Thus, if a state party has signed a treaty, but has not yet ratified it, that state is at least required not to act in opposition to the terms of the treaty. Taking opposite action could be interpreted by other parties as rejection of the treaty.

### **2.3.3.2 States' Obligations After Ratification**

In general, whatever its legal source, international rules obligate states and it can be expected that states will undertake the necessary steps to show respect for international rules.<sup>314</sup> In terms of the right to health care, the International Committee has explained the obligations on states that are needed to respect it.<sup>315</sup> In 1986, the Limburg Principles on the implementation of economic, social and cultural rights were adopted by international jurists from different parts of the World. In these principles, international scholars agreed

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<sup>312</sup>This noted by article (12) of Vienna convention which provides "1.The consent of a State to be bound by a treaty is expressed by the signature of its representative when: (a) the treaty provides that signature shall have that effect; (b) it is otherwise established that the negotiating States were agreed that signature should have that effect; or (c) the intention of the State to give that effect to the signature appears from the full powers of its representative or was expressed during the negotiation.

2.For the purposes of paragraph 1: (a) the initialing of a text constitutes a signature of the treaty when it is established that the negotiating States so agreed; (b) the signature ad referendum of a treaty by a representative, if confirmed by his State, constitutes a full signature of the treaty.

<sup>313</sup>Brownlie, *Principles of Public International Law*. 582. Shaw, *International Law*. 817-818

<sup>314</sup>Article (2) of the ICESCR provides "1. 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. 2. The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. 3. Developing countries, with due regard to human rights and their national economy, may determine to what extent they would guarantee the economic rights recognized in the present Covenant to non-nationals."

<sup>315</sup>General Comment No 14

unanimously on the main issues such as The Nature and Scope of States Parties' Obligations.<sup>316</sup> As already noted, health care has been mentioned in several international conventions.<sup>317</sup> The obligation generated by these conventions is to provide health care services to individuals irrespective of sex, gender, religion and age. Additionally it is important to classify the obligations that derive from such a right.

Given the fact that these treaties have resulted in a different understanding of the nature of obligations, some scholars believe that a state's obligations under the right to health care are, because of resource constraints, only conduct obligations and not result obligations.<sup>318</sup> An obligation of conduct, as is explained in The Maastricht Guidelines, "requires action reasonably calculated to realize the enjoyment of a particular right."<sup>319</sup> The Maastricht Guidelines also describe an obligation of result which "requires States to achieve specific targets to satisfy a detailed substantive standard."<sup>320</sup> On this view, it is clear that ratification of a treaty requires the state party to accept international monitoring of their compliance with its terms. In addition, a state party is sometimes required to submit an annual report to the treaty body. In the case of health care, at national level, it is not sufficient for the government to say that it has fulfilled its obligations merely by adopting a national health care system. Rather, it is required to ensure that the health care system can and does achieve its health targets.

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<sup>316</sup>"The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights," *Human Rights Quarterly* 9, no. 2 (1987). 122-35 see also *David L. Martin*. The Limburg Principles turn ten: an impact assessment. Online at <http://www.uu.nl/uupublish/content/20-09.pdf>

<sup>317</sup>In general, and as with other socioeconomic rights, discussing the effects of international law required using general comments No (3) and No (14) as well as other sources of international law. In its comments, the International Committee tried to describe what legal effects derive from the ICESCR in general and Article 12 specifically. Before beginning to study these effects, it is important to note that right to health care was not only a subject of the ICESCR but it also of other conventions such as the Convention on the Elimination of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (CHR), and the ICESCR.

<sup>318</sup>Dennis and Stewart, "Justiciability of Economic, Social, and Cultural Rights: Should There Be an International Complaints Mechanism to Adjudicate the Rights to Food, Water, Housing, and Health?." 491 see also L. Chenwi, "Monitoring the Progressive Realisation of Socio-Economic Rights," [http://scholar.googleusercontent.com/scholar?q=cache:CfCESiFocQAJ:scholar.google.com/+Monitoring+the+Progressive+Realisation+of+Socio-Economic+Rights&hl=en&as\\_sdt=0,5](http://scholar.googleusercontent.com/scholar?q=cache:CfCESiFocQAJ:scholar.google.com/+Monitoring+the+Progressive+Realisation+of+Socio-Economic+Rights&hl=en&as_sdt=0,5). 15

<sup>319</sup> Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, 4 available at <http://www.uu.nl/uupublish/content/20-01.pdf> accessed 04-10-2008.

<sup>320</sup>*Ibid.* 4

It is instructive here to note that the effect of a right to health care in individual states is not always an ‘obligation of conduct’ but the nature of such an obligation, as pointed out by Tinta, is an ‘obligation of results’ regardless of the availability of resources.<sup>321</sup>

To return to states’ obligations, the Committee introduced three obligations that states have to undertake to implement the right to health which, as has been highlighted above, for the purposes of this thesis should be taken to mean the right to health care. With respect to this right, as Teobes points out,<sup>322</sup> states require to respect, to protect, and to fulfil. In the following sections, an explanation will be offered as to what these obligations mean and what states should do to implement them.

### **2.3.3.2.1 The Obligation to Respect**

In his final report, Eide describes the obligation to respect as follows:

The obligation to respect requires the State, and thereby all its organs and agents, to abstain from doing anything that violates the integrity of the individual or infringes on his or her freedom, including the freedom to use the material resources available to that individual in the way she or he finds best to justify the basic needs.<sup>323</sup>

In its General Comment No 14, the International Committee explained this obligation in a way that results in two sorts of obligations: national and international obligations.

At the international level, according to article 12 of the Treaty, General Comment No 14 points out that States parties should respect the enjoyment of the right to health in other countries and should not assist any third party who tries to restrict or interrupt such enjoyment. Instead, States parties are required to act positively and effectively in the spirit of Article 56 of the Charter of the United Nations and the Alma-Ata Declaration on primary health care<sup>324</sup> which declare that States parties ought to understand the fundamental role of international cooperation. International cooperation in the health sphere is important

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<sup>321</sup>Tinta, "Justiciability of Economic, Social, and Cultural Rights in the Inter-American System of Protection of Human Rights: Beyond Traditional Paradigms and Notions". 26 see also K.G. Young, "Minimum Core of Economic and Social Rights: A Concept in Search of Content, The," *Yale J. Int'l L.* 33(2008). 121-25

<sup>322</sup>Teobes, *The Right to Health as a Human Right in International Law*. 311-12, World Health Organization, "The Right to Health—the Fact Sheet," (Geneva, Switzerland: WHO, 2007). 25-26

<sup>323</sup>A. Eide, *Right to Adequate Food as a Human Right*, vol. 1 (United Nations Pubns, 1989). 14

<sup>324</sup>WHO. Declaration of Alma Ata, The International Conference on Primary Health Care, 1978 available on line at [http://www.who.int/hpr/NPH/docs/declaration\\_almaata.pdf](http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf) accessed on 9/12/2010

not only to prevent other states from having health problems but also as one of the solutions to the scarcity of resources, especially in poor countries.<sup>325</sup>

At national level, the obligation to respect, in relation to the right to health care, means that the state is required to refrain from interfering with, restricting or refusing equal access for all persons.<sup>326</sup> In addition, the International Committee also required states to respect traditional preventive care. From the General Comment perspective, States parties should refrain from marketing unsafe drugs or applying coercive treatment.<sup>327</sup>

In relation to the obligation to respect, Toebes makes a very good point that shows the its nature. She argues that the state's obligation to respect means that it is an obligation of results not only an obligation of conduct. In her opinion, the state requires to respect its obligation in a way that enables it to attain positive outcomes. Therefore, such an obligation is justiciable.<sup>328</sup>Toebes's view can be used as a first step in this thesis to emphasize that the real nature of the obligations resulting from the International Convention on Economic, Social, and Cultural Rights could achieve full realization of the right to health care and not only simply that states should 'do their best'. At this stage it is important to realize that states are obligated by the Covenant not only to respect but also to protect.

#### **2.3.3.2.2 The Obligation to Protect**

Generally speaking, saying that something is a 'right' means that it is protected by law. The obligation to protect, in terms of the right to health care, means that the state should take positive steps to guarantee equal access to health care.

Eide also explained the obligation to protect, in his final report, in this way:

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<sup>325</sup>The United Nations, Office of the High Commissioner for Human rights, General Comment No 14, <http://www.unhcr.org/cgi-bin/texis/vtx/refworld/rwmain?docid=4538838d0&page=search> accessed 30/07/2012

<sup>326</sup>Sellin, "Justiciability of the Right to Health: Access to Medicines-the South African and Indian Experience." 449 see also for more details Manisuli Ssenyonjo, *Economic, Social and Cultural Rights in International Law* (Hart Pub, 2009). 336-39

<sup>327</sup>General Comment No 14. section 34, D.M. Chirwa, "Right to Health in International Law: Its Implications for the Obligations of State and Non-State Actors in Ensuring Access to Essential Medicine," *S. Afr. J. on Hum. Rts.* 19(2003). 558

<sup>328</sup>Toebes, *The Right to Health as a Human Right in International Law*. 313, Organization, "The Right to Health—the Fact Sheet." 26

The obligation to protect requires from the state and its agents the measures necessary to prevent other individuals or groups from violating the integrity, freedom of action or other human rights of the individual – including the prevention of infringement of the enjoyment of his material resources.<sup>329</sup>

In his view, the obligation to protect is similar to the obligation to respect and has two dimensions: social and freedom. The state should enact appropriate legislation that ensures equal access to health care for all citizens. Such legislation should create an adequate health care system which guarantees that health care services are offered by providers (private or public) without a threat to availability, accessibility, acceptability and quality. In terms of the obligation to protect, States also require to ensure that all medical practitioners and other healthcare professionals have adequate qualifications that allow them to practise.<sup>330</sup>

In this context, it is important to note that the General Comment pays special attention to vulnerable groups such as women and children; the Comment states that governments are obligated to ensure that no one can force women to undergo traditional practices and that third parties do not limit other people's access to health services.<sup>331</sup>

With regard to the obligation to protect, it is important to note that availability, accessibility, acceptability, quality and we can add affordability, are not only principles of the right to health care as a human right; rather they should be seen as ways of providing such a right. In other words, they are standards which providers should take into account when they provide health care services. Although these standards have nothing to do with the legal status of the right to health care they still, as pointed out by McLean *et al*, play a fundamental role in providing justice and equity for citizens. In other words, citizens will be able to expect that a health service which operates under these standards is fair and sufficient even if the service does not fully meet their needs because of scarcity of resources.<sup>332</sup>

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<sup>329</sup>Eide, *Right to Adequate Food as a Human Right*. 14-15

<sup>330</sup>Chirwa, "Right to Health in International Law: Its Implications for the Obligations of State and Non-State Actors in Ensuring Access to Essential Medicine." 559-560

<sup>331</sup>General Comment No 14. section 35

<sup>332</sup>Sheila McLean, "Ethico-Legal Decision-Making in Healthcare." 23-31

In relation to the right to health care, the obligation to protect also means that the state should protect citizens from violation by pharmaceutical companies, for example, by controlling the marketing of medicines and ensuring that competition rules have been respected by all parties. In this regard, it is worth noting that such an obligation is not only a domestic obligation - it is also an international obligation. In terms of the obligation to protect, there is disagreement about the capability of the courts to evaluate and judge this obligation.<sup>333</sup>

As will be seen later in this chapter, some writers believe that courts are not capable of dealing with issues such as health care because this is a political issue and forms 'core elements of national policy'.<sup>334</sup> Therefore, these writers reject the intervention of non-elected bodies, such as courts, in public policy such as health care affairs or distribution of the public budget.<sup>335</sup> In contrast, other jurists have supported the jurisdiction of the courts in adjudicating on public policy, specifically in evaluating the actions of governments and how these actions influence the rights of citizens, especially in relation to issues such as health care matters.<sup>336</sup> Unlike the obligation to respect, Toebes argues that the obligation to protect is unlikely to be justiciable because it requires positive action.<sup>337</sup> In response, it can be argued that disputes between the state and citizen often arise in situations that require positive actions rather than negative actions. Thus, judicial intervention is required. For this reason, positive obligations should be equivalent to negative rights.<sup>338</sup>

Finally, it should be clear that the obligation to protect means to protect the human right to health care of individuals from any illegal intervention by others, whether they are third parties, agents of the state, such as prisons and hospitals, or family members. It is also important to note that the responsibility of the state exists even if the health system is privatized. The state is required to enact all appropriate legislation to ensure that the quality of health services is ensured and health standards are respected in the way that

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<sup>333</sup>Ssenyonjo, *Economic, Social and Cultural Rights in International Law*. 339-40

<sup>334</sup>Sellin, "Justiciability of the Right to Health: Access to Medicines-the South African and Indian Experience." 452

<sup>335</sup>*Ibid.* 452 see also A.C. Hutchinson, "Judges and Politics: An Essay from Canada," *Legal Studies* 24, no. 1-2 (2004). 277-78

<sup>336</sup>G.F. Anderson, "The Courts and Health Policy: Strengths and Limitations," *Health Affairs* 11, no. 4 (1992). 108 see also Mapulanga-Hulston, "Examining the Justiciability of Economic, Social and Cultural Rights." 43

<sup>337</sup>Toebes, *The Right to Health as a Human Right in International Law*. 327

<sup>338</sup>A. Bradley, "Positive Rights, Negative Rights and Health Care," *Journal of medical ethics* 36, no. 12 (2010).

would be the case if the state provided such services directly by itself. Supervision by the state of the health care system is always required, whether it is provided by governmental institutions or not.<sup>339</sup>

### **2.3.3.2.3 The Obligation to Fulfil**

In its General Comment No 14, the International Committee explained the obligation to fulfil as follows:

The obligation to fulfil requires States parties, inter alia, to give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realizing the right to health.<sup>340</sup>

Similarly, Eide has described the obligation to fulfil as follows: “the obligation to fulfil requires the State to decide all necessary measures to ensure for each person within its jurisdiction opportunities to obtain satisfaction of those needs, recognised in the human rights instruments, which cannot be secured by personal efforts.”<sup>341</sup>

On closer scrutiny, it can be observed that, under the obligation to fulfil, the duties of States parties are likely to be more problematic than in the two other obligations especially in the developing countries where financial resources are scarce, but we need to bear in mind that the first reading of the Convention on Economic, Social and Political Rights, specifically Article 2 and article 12, shows that the application of the obligation to protect is under condition of the availability of resources, so if the government has plenty of resources to offer a good health service, such authority is required to undertake all necessary steps to protect individuals’ health.

Generally, the obligation to fulfil requires States parties to provide health care services to each person who lives in their jurisdiction, whether this is a primary or an advanced service. To clarify, it is not reasonable to require states such as Tanzania to offer health services to the same standard as that provided in Japan, but what should be clear is that the

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<sup>339</sup>See Toebes, *The Right to Health as a Human Right in International Law*. 328, Toebes, "The Right to Health."

<sup>340</sup>General Comment No 14. para 12-13, Chirwa, "Right to Health in International Law: Its Implications for the Obligations of State and Non-State Actors in Ensuring Access to Essential Medicine." 560-561

<sup>341</sup>Eide, *Right to Adequate Food as a Human Right*. 15, Organization, "The Right to Health—the Fact Sheet." 27

state must provide a health care service. In addition, it should be also clear that the right to this health service should be legally and politically recognized, which means that the adoption of legislation may be necessary as will be the provision of an appropriate budget.<sup>342</sup>

Another important point is that the obligation to fulfil can play a key role in the clarification of the core of a right. By implementing such an obligation, states can be clear on what health services can be provided, how and to whom. A good balance between health needs and available resources surely can give optimum results. In other words, states can evaluate how to manage available resources to gain at least a minimum standard of health care. However, the adoption of health legislation often is not enough to achieve good health care. In Libya, for instance, there has been health legislation at least since 1973 but because of corruption and an inappropriate health system Libyans often have to go abroad to obtain good health services. In contrast, Tunisia, with limited resources, was able to offer a high standard of health service to its citizens. This will be discussed in more detail in the coming chapters.

Last, but not least, the argument presented here contends that the obligation to fulfil can be and is justiciable.<sup>343</sup> This will be discussed further in subsequent chapters. For the moment, suffice it to say that if we can agree that the right to health care ‘is or should be seen as a human right’, then it is subject to law. Courts are part of the law, not only in terms of law enforcement but also as lawmakers and protectors. In terms of international human rights, particularly the right to health care, courts should be authorized to address any violations that may be committed by governments, such as the adoption of an inadequate health system, failure to enact health legislation as required by international obligations or failure to take the necessary steps to save the lives of its citizens in relation to health affairs. It is essential also to note that the obligation to fulfil should include international assistance that countries have to provide to poor countries. This does not mean only offering drugs, but also health information and technology as needed.

Finally, it is important to remember that human rights obligations are different from other obligations that states have under other national or international agreements. In respect of human rights obligations, the state is required to take certain steps to vindicate rights as

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<sup>342</sup>Ssenyonjo, *Economic, Social and Cultural Rights in International Law*. 340-41

<sup>343</sup>Toebe, *The Right to Health as a Human Right in International Law*. 328

well as having attention to general principles such as equity, non-discrimination and participation. Such principles are important for achieving real human rights to health care, as will be explained later.

## **2.4 General Principles of the Right to Health Care**

The right to health care, if recognised, would be controlled by general principles that explain how it can be achieved. General principles of human rights are also obligations that states are required by international human rights law to accept. Applying these obligations is necessary to accomplish human rights in an appropriate way. For example, no one can speak about human rights where there is different treatment of black and white people, solely on the basis of colour. Human rights must be provided without discrimination and with due regard to equity and fairness. In the following section, the relationship between the proposed right to health care and the general principles of human rights will be explored, as will be the contribution of these principles to clarification of the legal characteristics of the right.

### **2.4.1 Equity**

Equity is an essential element of human rights which are founded on the need for equitable treatment. Equitable action demands that public services should be provided to all citizens equally without any difference based on sex, age, gender or religion. In fact, equity is not only a foundational principle of human rights but it should also be seen as the main aim of the law in general.<sup>344</sup>

In these terms, equity is broadly equivalent to social equality. Thus, the importance of equity in national and international laws is explained by saying that the purpose of law is not only to end any dispute between public interests and individual concerns, as well as between individuals themselves, but also to act equitably between them by taking into account the circumstances of each case.<sup>345</sup> As Whitehead pointed out, equity does not mean that everyone should have the same health status or consume the same level of health

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<sup>344</sup>E. Zere et al., "Equity in Health Care in Namibia: Developing a Needs-Based Resource Allocation Formula Using Principal Components Analysis," *International Journal for Equity in Health* 6, no. 1 (2007). 1, M. Akehurst, "Equity and General Principles of Law," *Int'l & Comp. LQ* 25(1976).M. White, "Equity-a General Principle of Law Recognised by Civilised Nations," *Queensland U. Tech. L. & Just. J.* 4(2004).

<sup>345</sup>A. McColgan, *Discrimination Law: Text, Cases and Materials* 2ed. (Hart Publishing, 2005). 139-55

services.<sup>346</sup> Human beings can never reach the position where everyone in the population has the same level of health or experiences the same kind and degree of illness or lives as many years as other people do.<sup>347</sup> The difference between equity and equality should be clear, even though both have ethical roots.<sup>348</sup>

In terms of human rights, equity should be seen not only as a general principle but also as a fundamental tool in their implementation. For instance, if a health system is built on a distinction between citizens based on sex, religion, colour or anything else that is otherwise irrelevant, that health scheme will not be successful. But, for example, this does not mean paying special attention to a disadvantaged area or people would cause inequity in health care services. On this view, it is important to note the difference between general principles of human rights and the characteristics of human rights. The interdependence, interrelation and indivisibility of human rights does not mean that a human right to health care, for example, cannot be implemented until other human rights are, but one may say that these characteristics imply that the state should deal with human rights as a whole and not individually.<sup>349</sup> Equity as a general principle will be required in either single or sets of human rights. In contrast, the characteristics of human rights do not mean that other related human rights are included in a right to health care. They may be affected by, or have influence on, the right to health care but they will never mean that the right to health care is equivalent to the right to a healthy environment or the right to housing.

In terms of equity, General Comment No 14 states that the right to health (care) will encompass four elements. According to the General Comment, equity in the right to health care means availability, accessibility, acceptability and equality<sup>350</sup>. In Scotland, in a health service project, McLean's research reaffirmed these elements.<sup>351</sup>

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<sup>346</sup>Whitehead, "The Concepts and Principles of Equity and Health." 15, P. Braveman, "Health Disparities and Health Equity: Concepts and Measurement," *Annu. Rev. Public Health* 27(2006).

<sup>347</sup>W. Margaret, "The Concepts and Principles of Equity and Health," *World Health Organization. Regional Office for Europe. Copenhagen* (2000). 6

<sup>348</sup>P. Braveman and S. Gruskin, "Defining Equity in Health," *Journal of epidemiology and community health* 57, no. 4 (2003). 255

<sup>349</sup>See Vienna Declaration and Programme of Action (A/CONF. 157/23), adopted by the World Conference on Human Rights, held in Vienna, 14-25 June 1993.

<sup>350</sup>.Economic and Social Council. 2000. General comment No 14

<sup>15</sup>Sheila McLean, "Ethico-Legal Decision-Making in Healthcare."

In keeping with this, one could argue that linking health and equity together might provide a good opportunity to institute a workable health care system that takes into account the legal aspects of health care as a human right. Indeed, Whitehead points out that equity demands the participation of all partners in order to accomplish the right to health (care).<sup>352</sup>

## 2.4.2 Non- discrimination

States parties of the ICESCR are required to undertake the necessary steps to guarantee that the rights promulgated in the agreement will be implemented without discrimination.<sup>353</sup>

The ICESCR states clearly that “the states parties to the present covenant undertake to guarantee that the rights enunciated in the present covenant will be exercised without discrimination of any kind as to race, colour, property, birth or other status.”<sup>354</sup>

In terms of the right to health care, non-discrimination should not be only considered as a principle but it also a commitment to treating everyone in a fair way in regardless of religion, sex, colour and age. Any kind of discrimination in the implementation of the right to health care will negatively affect all of the state’s policies. Recognizing health care as human right would not only mean that one can have access to medical treatment but it would also include freedoms and entitlements such as the right to be free from discrimination.<sup>355</sup> At this stage, it is important to note – as with the concept of equity - that non-discrimination does not mean that special attention cannot be paid to vulnerable groups in society. In some cases, special services are required to end discrimination. Equal and effective human rights protection for vulnerable groups should be offered by the state’s authorities.

It is also important to note that sometimes governments make policy based on so-called ‘positive discrimination’ with the aim of encouraging specific groups who suffer from

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<sup>352</sup>Whitehead, "The Concepts and Principles of Equity and Health." 15, Organization, "The Right to Health—the Fact Sheet." 7-9

<sup>353</sup>Committee on Economic, Social and Cultural Rights, General Comment No 20 Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights), E/C.12/GC/20/2 July 2009 available at <http://www2.ohchr.org/english/bodies/cescr/docs/E.C.12.GC.20.doc> accessed 15/08/2010

<sup>354</sup> International covenant on economic, social and cultural rights, Article (2) paragraph (2). The UN. Available at <http://www2.ohchr.org/english/law/cescr.htm> accessed 15/08/2010.

<sup>355</sup>P. Hunt, "The Human Right to the Highest Attainable Standard of Health: New Opportunities and Challenges," *Transactions of the Royal Society of Tropical Medicine and Hygiene* 100, no. 7 (2006). 604

common discrimination to benefit.<sup>356</sup> For instance, providers sometimes have attempted to make a list of health services based on the health status of a specific group of people such as women, children, and the elderly, who might need to be given special consideration.<sup>357</sup> In several cases, English courts have supported this trend and indicated rightly that such behaviour is not unlawful. In *Lambeth London Borough Council v Commission for Racial Equality*, for example, Balcombe LJ stated that if the Race Relations Act of 1976 ss. 35-38, permits for some exceptions and the government applied these exceptions, it is not illegal to afford persons of a particular group access to facilities or services to meet their special needs.<sup>358</sup>

As Mann has pointed out, the provision of health services could depend on sex, religion, age, or any other characteristic which may be important to allow health providers to improve the health situation of certain groups in society.<sup>359</sup> Thus, it should be clear that paying special attention to women's health, for instance, in situations such as pregnancy, confinement and the post-natal period is required and would not be considered as discrimination. In terms of the right to health care, non-discrimination holds a special place because of the existence of potentially vulnerable groups such as older people and children, as a result of their dependence on others for their basic needs. For this reason, health authorities are required to pay special attention to these groups.<sup>360</sup> Relevant differentiation does not amount to discrimination. It is also necessary to remark that if proportionality is taken into account in state action, the action cannot be considered as negative discrimination; in fact, it is positive discrimination which is justified and acceptable.<sup>361</sup>

There is general agreement that non-discrimination is an essential principle that states and individuals must take into account when they try to implement human rights, particularly the right to health care. In addition, non-discrimination is frequently required directly and indirectly by international human rights bodies and treaties. In these terms, it is clear that

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<sup>356</sup>D. Harris S. Bailey, and B. Jones *Cases and Materials on Civil Liberties* (London: Butterworths, 2002). 1083

<sup>357</sup>Access to Health Care, Report of a Scoping Exercise for the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO), 2001,

<sup>358</sup>[1990] IRLR 231, 234, CA.

<sup>359</sup>J. M. Mann, *Health and Human Rights: A Reader* (Psychology Press, 1999).12

<sup>360</sup>Joint Committee on Human Rights, *The Human Rights of Older People in Healthcare*, 19-27

<sup>361</sup>D. Feldman, "Proportionality and Discrimination in Anti-Terrorism Legislation," *The Cambridge Law Journal* (2005). 271-273, see also for details A. Baker, "Proportionality and Employment Discrimination in the UK," *Industrial Law Journal* 37, no. 4 (2008). 305-28

states are legally obliged to avoid any kind of discrimination; otherwise they must be ready to take responsibility for ignoring this principle.<sup>362</sup>

### 2.4.3 Participation

Involvement of citizens, including patients, in the implementation of human rights can arise at two levels - national and international. At a national level, participation by health authorities, individuals and non-governmental organizations may be required. In order to improve or apply the right to health care, all actors in the local community could play a significant role in helping to achieve the goals of the health care system.<sup>363</sup> For instance, health regulation in Libya assumes that doctors, family members, school teachers and the police have a duty to notify any contagious disease to the health authorities.<sup>364</sup> UK human rights law has also promoted the participation of patients and community in a way that improves the responsibility of health care in society.<sup>365</sup>

At a national level, there are another two participants who could and should play a vital role in the health affairs in the state. First, healthcare professionals must be not only seen as a part of the health system but they should also have the chance to react effectively to improve health services in the country. Because of their position, healthcare professionals could help the state as well as individuals to take account of the major health problems in society. This role has been discussed by many writers who believe that healthcare professionals play an essential role in health issues in any society.<sup>366</sup> For this reason, historically, medical professionals always have been respected and trusted by the public. Some writers such as Hunt point out that participation in health-related matters by healthcare professionals assists them to understand and deal with health problems in such a way as to help resolve the healthcare challenges that society might face at any time.<sup>367</sup>

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<sup>362</sup>For more information see international human rights bill (UDHR-ICCPR-ICESCR), the UN Charter, the Covenant on the Elimination of all forms of discrimination against woman (CEDAW) and Covenant of the rights of the child and other human rights documents.

<sup>363</sup>Chirwa, "Right to Health in International Law: Its Implications for the Obligations of State and Non-State Actors in Ensuring Access to Essential Medicine." 542

<sup>364</sup>.Libyan health regulation on health law No 106/1973.Article 188.

<sup>365</sup>A. Green, D. Ross, and T. Mirzoev, "Primary Health Care and England: The Coming of Age of Alma Ata?," *Health Policy* 80, no. 1 (2007). 19 see also V. Harpwood, "Proposals to Modify the Delivery of Healthcare in the Uk," *Eur. J. Health L.* 5(1998). 6

<sup>366</sup>E. Wicks, *Human Rights and Healthcare* (Hart Pub., 2007). 12-14

<sup>367</sup>Hunt, "Special Rapporteur Report to the International Committee on Human Rights.", para 95, 22

Another fundamental actor in healthcare issues is the courts. Access to courts of law can be important, especially when vulnerable groups are given less than their needs. Additionally, courts can clarify the meaning of the right to health care and in general what it means to have this right. Courts can evaluate the decisions of policy makers and describe why they may be right or wrong. As will be discussed later in this thesis, the intervention of courts in health issues is required to establish a clear legal framework for the right to health care.

In regard to the state's role, international agreements - including the UN charter - have clearly required states to promote and protect human rights. Promotion and protection of human rights by states requires the adoption of a human rights agenda that leads to the guarantee of, and respect for, human rights, nationally and internationally. In the ICESCR, Art (2) Para (1) states that:

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.<sup>368</sup>

Over the last three decades, the participation of individuals has been gradually increased. The international community and individual states have realized that successful implementation of human rights requires a positive contribution from citizens. In 1978, the Alma Ata declaration stated that the involvement of the population in health programmes is necessary for their success.<sup>369</sup>

This view has been accepted by many international documents which insist that the contribution of citizens in implementing the right to health care and other human rights is necessary not only for success but also for recognition of the importance of human rights in their lives.<sup>370</sup> Agreeing with this view, Hunt has pointed out the responsibility of all participants, including the business sector, in implementing the right to health care.<sup>371</sup> The

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<sup>368</sup> The United Nation, the ICESCR. Online at <http://www2.ohchr.org/english/law/cescr.htm> accessed 07/11/2012

<sup>369</sup> WHO. Alma Ata Declaration. 6-12/September/1978. online at [http://www.who.int/hpr/NPH/docs/declaration\\_almaata.pdf](http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf) accessed 24/04/2012

<sup>370</sup> Green, Ross, and Mirzoev, "Primary Health Care and England: The Coming of Age of Alma Ata?." 19

<sup>371</sup> Hunt, "Special Rapporteur Report to the International Committee on Human Rights."

importance of the participation by all actors has also been clearly stated by Chirwa. In his article on ensuring access to essential medicine, Chirwa emphasizes that the recognition of human rights needs the action of many actors other than the government.<sup>372</sup>

In terms of the right to health care, participation has special value; therefore, it can be seen not only as a fundamental principle of human rights but also can play a significant role in building the awareness of citizens as to their rights and how they can enjoy them. Furthermore, participation in implementing the right to health care includes not only the ability to make decisions but also the capacity to participate in the enforcement and monitoring of how these decisions are implemented in practice.<sup>373</sup>

In short, participation in the implementation of health plans and decisions is required to enhance the value of the proposed right to health care. Moreover, responsibility for health activities will be clarified. As a result, everyone would know his/her rights and duties and would understand what is meant by a right to health care. To sum up, it is clear that without the application of the principles outlined above, human rights in general, and particularly the right to health care, will have no force.

## **2.5 Justiciability of the Right to Health Care**

Whether as a legal or a human right, health care claims should be protected by law. Protection by law means that the right-holder can exercise it without being hindered by others. Should hindrance appear, the right-holder can use all permitted mechanisms to vindicate his or her right. One of these permitted mechanisms is raising a claim through the courts. In fact, this is the most important method, and in many cases, it is the final solution to any conflict.<sup>374</sup>

According to Scheinin, protection of rights by courts can also help in understanding their nature, which then explains why positive state obligations must be fulfilled.<sup>375</sup> Right-holders

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<sup>372</sup>Chirwa, "Right to Health in International Law: Its Implications for the Obligations of State and Non-State Actors in Ensuring Access to Essential Medicine." 542

<sup>373</sup>A. Coulter et al., "Implementing Shared Decision Making in the UK," *Zeitschrift für Evidenz, Fortbildung und Qualität im Gesundheitswesen* 105, no. 4 (2011). Sheila McLean, "Ethico-Legal Decision-Making in Healthcare." 27

<sup>374</sup>E. Wiles, "Aspirational Principles or Enforceable Rights? The Future for Socio-Economic Rights in National Law" (2006), *American University International Law Review* 22. 36

<sup>375</sup>Scheinin, "Economic and Social Rights as Legal Rights." 62

often do not believe that rights are legal rights unless they are protected by courts. In terms of a right to health care, there are two different views about its justiciability. The first is represented by academic writers who argue that any such right cannot be a subject matter for courts.<sup>376</sup> Furthermore, this is not only the attitude of some scholars; in fact, courts have also adopted this view. For instance, the USA courts, including the Supreme Court, still follow this tendency.<sup>377</sup> In contrast, there is second trend where the majority of jurists argue that these rights are justiciable in the same way as political and civil rights.<sup>378</sup> Thus courts can and should adjudicate governmental health policies whenever they are required to do so by citizens.

The justiciability of the right to health care cannot be described without talking about the separation of rights into two categories and reflection on the impact of this separation on the legal status of rights in general. As was indicated above, the ideological conflict between Western and Eastern countries during the Cold War was behind this separation. As result, socioeconomic rights, including any claimed right to health care, were not enforced immediately in the way that civil and political rights were. The latter were treated as full human rights whereas the former were seen as aspirational goals rather than real human rights.

Thus, the treatment of social rights in international law had an impact on the engagement of courts. However, this was unacceptable to the international community as well as to the majority of legal jurists who frequently highlighted the importance of socio-economic rights, not merely as an indication of an equal society and solidarity but for the enjoyment of political and civil rights themselves.<sup>379</sup> In other words, the interdependent, interrelation and indivisibility of social and economic rights and political and civil rights cannot be ignored.

As already explained in the previous chapter, for commentators who remain sceptical about the justiciability of the right to health care, there are several reasons why such a right is unenforceable. As libertarians, they believe that rights mean 'freedom' which should be

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<sup>376</sup>Ibid. 41

<sup>377</sup>A. Jenkins and S. Ardalan, "Positive Health: The Human Right to Health Care under the New York State Constitution," *Fordham Urb. LJ* 35(2008). 483

<sup>378</sup> For example see Hervey, "The "Right to Health" in European Union Law." 195

<sup>379</sup> Vienna Declaration and Programme of Action (A/CONF. 157/23), adopted by the World Conference on Human Rights, held in Vienna, 14-25 June 1993

protected from any sort of intervention even by the state. Thus, the function of the state is merely to safeguard the individual from third part intervention and refrain from interference.

According to Marks, libertarians prefer freedom to 'equality' as a response to the long history of abuse, violation of rights and arbitrary exercise of power by the monarchy.<sup>380</sup> Therefore, the intervention of the state should be limited and an individual can do whatever he or she wants so long as that does not damage the rights of others. As a result, positive interventions by government are unwelcome.

Furthermore, this school of thought considers socioeconomic rights to be positive rights. Therefore, they are not as the same as civil and political rights which are negative. Considering social-economic rights as positive rights mean that there is a cost to the state in implementing them. As result, in the view of libertarians, spending public money is a governmental affair and as such it is not an appropriate subject for the judicial system.

In addition, it is important to note that the supporters of this school of thought have refuted the evidence produced by opponents, pointing to the content and intention of international documents and actions, plus the application of socioeconomic rights in domestic law and courts. It is also important to understand that recognition of human rights as 'claims' or 'entitlements' to a great extent depends on the specific form in which they are defined. This, however, should not be used to deny socioeconomic rights their status as full legal rights.<sup>381</sup>

Moreover, in its General Comment No 3, where the International Commission on Economic, Social, and Cultural Rights explained the obligations of the member states of the ICESCR, it clarified that one of the necessary steps that states shall take is enacting proper legislation and creating an effective system of remedies, including an independent judicial body.<sup>382</sup> These guidelines provide evidence that it was intended that all rights, including socioeconomic rights, would be justiciable. In addition, it is important to remark that the international community, represented on the UN General Assembly, agreed to adopt an Optional Protocol on Economic, Social and Cultural Rights which opened for

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<sup>380</sup>Marks, "Past and Future of the Separation of Human Rights into Categories." 224-27

<sup>381</sup>Mapulanga-Hulston, "Examining the Justiciability of Economic, Social and Cultural Rights." 42

<sup>382</sup> General Comment No 3 para 5 see also for details Bertrand G. Ramcharan, *Judicial Protection of Economic, Social and Cultural Rights: Cases and Materials* (M. Nijhoff Publishers, 2005). 26-30

signature and ratification in 2008. This Optional Protocol reinforces the assertion that socioeconomic rights are real rights and they can be justiciable since the Protocol aims to enable individuals and states to make a claim when these rights are violated.<sup>383</sup>

In general, one can say that all human rights, to varying degrees, are supposed to be legally protected. Therefore, the states parties of the ICESCR required the establishment of appropriate and effective mechanisms to monitor the vindication of rights, including courts. Courts can perform the function of clarifying the meaning and scope of rights. In the case of child B,<sup>384</sup> for example, the judgement of the court elucidated whether courts are competent to evaluate governmental decisions in regard to health affairs, and indeed can require reconsideration of policy decisions in the exceptional circumstances of specific cases.<sup>385</sup>

In terms of the right to health care specifically, there are many examples in national and international legal systems where this right has been the subject of a lawsuit.<sup>386</sup> These cases reflect that health care (albeit not always using this language) is protected legally whether by constitution, legislation, or even international treaty. This protection, in many cases under the use of interpretive procedure, allows the courts to support the justiciability of ESC rights. The Constitutional Court of South Africa has made good progress in this direction.<sup>387</sup> This work by domestic courts is sufficient answer to Forman and others who have stated that “[h]ealth has often fallen largely into the political rather than legal sphere, and domestic courts have been relatively reluctant to review health policies from a human rights perspective, given the belief that doing so would exceed the appropriate domestic function of the judiciary.”<sup>388</sup>

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<sup>383</sup> The UN General Assembly, Optional Protocol on Economic, Social, and Cultural Rights, resolution A/RES/63/117, on 10 December 2008 online at <http://www2.ohchr.org/english/bodies/cescr/docs/A-RES-63-117.pdf> last seen on 24/12/2010

<sup>384</sup> *R. V Cambridge DHA, Ex p. B* [1995] 2 All E.R. 129, [1995] 1 W.L.R. 898

<sup>385</sup> C. Ham, "Tragic Choices in Health Care: Lessons from the Child B Case," *Bmj* 319, no. 7219 (1999).

<sup>386</sup> In this thesis there are several cases support this point from national courts in India, South Africa, Brasil and UK and from international Courts such as Inter-American Court of Human Rights and European Court of Justice.

<sup>387</sup> Sellin, "Justiciability of the Right to Health: Access to Medicines-the South African and Indian Experience."

<sup>388</sup> Forman, "Ensuring Reasonable Health: Health Rights, the Judiciary, and South African Hiv/Aids Policy."

Those who do not recognise the legal status of the right to health care have also based their position on the separation of powers between the executive, legislature and judiciary. In their argument, health care policy should be made by the government and the legislature and not by courts otherwise the authority of the legislature in relation to health care policy making would be transferred to the judiciary who would become lawmakers instead of legal protectors.<sup>389</sup>

Here, it is important to remember that those commentators have also based some of their criticisms about the justiciability of such rights on the question of the availability of resources. This would entail that if the state has sufficient resources then states` obligations under the ICESCR would be justiciable and legally enforceable. Looking again to the example of the United States, where resources are vast but healthcare has traditionally been left to the free market, shows that this position is erroneous in reality

The function of the judiciary should not merely be seen as a sort of intervention in the work of the executive or legislature; rather, it often aims to correct situations and to resolve disputes that are instituted because there is a claim made by those whose interest is in question. In general, judicial control ought to be seen as one way to protect democracy.<sup>390</sup> If it is to be meaningful as a human right, the right to health care must be legally enforceable by state authorities, including in courts of law. Buchanan, amongst others, argues that enforcement of the right to health care as a universal right will offer the ethical foundation for using the coercive power of the state to assure a decent minimum for all.<sup>391</sup>

As mentioned above, justiciability of the right to health care would not only consolidate its ethical status, but also would identify and clarify its legal content. According to Shah, the intervention of the judiciary is necessary to remedy the inadequacies of government in order to guarantee that citizens are given their legal entitlements where the state has not taken its obligations sufficiently seriously.<sup>392</sup>

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<sup>389</sup>Littell, "Can a Constitutional Right to Health Guarantee Universal Health Care Coverage or Improved Health Outcomes: A Survey of Selected States." 294

<sup>390</sup>Tom Mullen., "Constitutional Protection of Human Rights," in *Human Rights: From Rhetoric to Reality*, ed. David Goldberg Tom Compbell, Sheila Mclean and Tom Mullen (Oxford: Basil Blackwell, 1986).

<sup>391</sup>Buchanan, "The Right to a Decent Minimum of Health Care." 58-66,Lie, "Human Rights, Equity and Health Sector Reform." 33

<sup>392</sup>Shah, "Illuminating the Possible in the Developing World: Guaranteeing the Human Right to Health in India." 472

Therefore, justiciability of the right to health care is required for several reasons. First, this will allow courts to deal with health care as a legal (even human) right and not as a political issue that is solely the prerogative of government. Most importantly, justiciability gives courts the ability to evaluate governmental health policy and resolve disputes between the individual and the state. In its general comments, the International Commission of Human Rights has stated that health plans and strategies should be based on the principles of accountability, transparency and independence of the judiciary.<sup>393</sup> Second, enforcement of the right to health care by the court will increase the ability of international human rights organisations - specifically the UN agencies – to intervene. In many cases, international institutions cannot interfere in health affairs unless the national courts have made their final decision on the matter. Simply, this would mean that without the recognition of the right to health care by domestic courts, enforcing this right internationally would not be possible.

Finally, it is important to highlight that the right to health care is not solely a political issue that judges cannot deal with because it is located in the authority of government. On the contrary, it is important to understand the functions of judges as explained by Mullen, who argues that “[j]udges’ duties are not only judgment but beyond this it also has empowered jurisdiction to protect individuals’ rights even it was violated by their own state’s authorities (executive or legislature). Both should know that each body has its own powers, however, that does not mean the ability to use them wrongly.”<sup>394</sup> In light of this, it is clear that the right to health care cannot be considered only as a political matter. Human rights are priority items on the public agenda and should not be treated only as aspects of everyday political decisions.<sup>395</sup>

In practice, there is no doubt that the right to health care is justiciable (at least indirectly) and citizens can rely on it to make a claim to obtain at least minimum health care services without discrimination. Such cases have been brought before courts in both developing and developed countries and have been adjudicated on by domestic and international courts.<sup>396</sup> As will be seen in chapter four, both European Courts (the ECJ and the ECtHR) have dealt with health affairs in the states parties and have treated health care as a legal right,

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<sup>393</sup>. The General comment no 14

<sup>394</sup>Mullen., "Constitutional Protection of Human Rights." 18

<sup>395</sup> See generally Nickel, "Are Human Rights Utopian?." 261

<sup>396</sup> For further discussion, see chapters 3 and 4, *infra*

whether directly or indirectly.<sup>397</sup> A similar position has been adopted by the Inter-American Court of Human Rights which protected the right to health care under the auspices of the right to life.<sup>398</sup> At national level, there are many instances where courts have adjudicated on health care policy in specific states and dealt with the question of the individuals` rights to complain about what the state offers to them, how it is provided, who provides it and when. As mentioned above, these cases come from developed countries such as the UK and developing countries such as the Republic of South Africa<sup>399</sup>, Brazil,<sup>400</sup> India<sup>401</sup> and Venezuela.<sup>402</sup>

In India, for instance, crucial steps have been taken by the Supreme Court to guarantee the right to health care for all. The court has forcefully emphasized that social rights are justiciable rights and therefore the courts have the capacity to judge health law and policy in the state in order to ensure that the law is used to enhance the lives of the poor and oppressed.<sup>403</sup>

However, it has been said that, in terms of the right to health care, courts might not be able to play an effective role, even if the right to health care is held to be justiciable.<sup>404</sup> In the view of Lie, while courts might have a role in reviewing the choices that made by politicians this is a limited role, which he argues will not have a significant influence on the health care system.<sup>405</sup> In response to such scepticism, it must be asked just where else individuals could go to ensure vindication of their rights? Some mechanism to ensure accountability is necessary, and this is a role that courts are used to playing. As Hunt and

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<sup>397</sup> Examples of the European cases is that N v the UK

<sup>398</sup> see Tinta, "Justiciability of Economic, Social, and Cultural Rights in the Inter-American System of Protection of Human Rights: Beyond Traditional Paradigms and Notions."

<sup>399</sup> G.J. Annas, "The Right to Health and the Nevirapine Case in South Africa," *New England Journal of Medicine* 348, no. 8 (2003).

<sup>400</sup> J. Biehl et al., "Judicialisation of the Right to Health in Brazil," *Lancet (London, England)* 373, no. 9682 (2009). J. Biehl et al., "Between the Court and the Clinic: Lawsuits for Medicines and the Right to Health in Brazil," *Health and Human Rights: An International Journal* 14, no. 1 (2012).

<sup>401</sup> K.S. Reddy et al., "Towards Achievement of Universal Health Care in India by 2020: A Call to Action," *The Lancet* 377, no. 9767 (2011). Shah, "Illuminating the Possible in the Developing World: Guaranteeing the Human Right to Health in India." V. Patel et al., "Universal Health Care in India: The Time Is Right," *The Lancet* 377, no. 9764 (2011).

<sup>402</sup> Yamin, "Protecting and Promoting the Right to Health in Latin America: Selected Experiences from the Field."

<sup>403</sup> Shah, "Illuminating the Possible in the Developing World: Guaranteeing the Human Right to Health in India". 472

<sup>404</sup> Lie, "Human Rights, Equity and Health Sector Reform." 33

<sup>405</sup> Ibid. 33

De Mesquita state “[w]ithout mechanisms of accountability the obligations arising from the right to health are unlikely to be fully respected.”<sup>406</sup>

As will be explained in the next chapter, court decisions can be used as a source of the right to health care and this is important for the clarity of this right, especially in regard to its definition and content. Historically, in many cases and in many countries, court judgements have played a fundamental role in clarifying many disputed legal issues between states and citizens and/or between states` authorities themselves.

It is important to evaluate the function of courts in hearing legal cases. Courts can clarify the powers of the state and potentially expand the extent of individuals` freedom. Secondly, courts can interpret the powers or duties of the state in a way that can redress imbalances and help individuals to enjoy rights in reality. According to Halley, it is important that any right is enforceable. In Halley’s words, “[a] legal right is entitlement to a benefit that can be justified (and thus enforced) by an appeal to the laws of the state”.<sup>407</sup> In addition, governments are sensitive to court interventions in public policy, As the Libyan Supreme Court has highlighted, court decisions should be seen as a way of improving the work of government and emphasise justice.<sup>408</sup> The interdependence between social rights and political rights is not just a theoretical assumption; rather, political and civil rights cannot be completely implemented until social rights are also taken seriously.<sup>409</sup>

As will be seen later, many benefits would flow from recognising the right to health care as a justiciable right. Initially, individuals would be allowed to use the courts in order to vindicate their rights. A justiciable right to health care would also mean that in order to avoid the supervision of the judicial authorities, government would be required to devote part of its budget to health care issues.<sup>410</sup> Finally and most importantly, it should be clear that, although courts would not be the only bodies responsible for implementing and developing the right to health care, they would be responsible for ensuring that delivery of

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<sup>406</sup>Paul Hunt and Judith De Mesquita, The rights to sexual and reproductive health, Human rights centre, University of Essex, at 10, available at [http://ec.europa.eu/europeaid/where/worldwide/health/documents/essex\\_sexualhealth\\_en.pdf](http://ec.europa.eu/europeaid/where/worldwide/health/documents/essex_sexualhealth_en.pdf) accessed 21/09/2010

<sup>407</sup>Halley, "Right to Health Care: Key Policy Issue or Useless Concept?." 103

<sup>408</sup>Supreme Court Decision No.Libyan Supreme Court Journal.Vol. No.

<sup>409</sup>Tinta, "Justiciability of Economic, Social, and Cultural Rights in the Inter-American System of Protection of Human Rights: Beyond Traditional Paradigms and Notions." 434

<sup>410</sup>Osiatynski, "Rights in New Constitutions of East Central Europe."

the right to health care meets the legal requirements of human rights law. In addition, courts can highlight any deficits in government performance.<sup>411</sup> In many cases, courts have played a fundamental role in establishing of the legal basis of right to health care. In South Africa, for instance, the existing right to health care was not only explained by the Supreme Court but also played a major role in pushing the government to enact health legislation and adopt a national health system. Although in 1996 the South African Constitution<sup>412</sup> described the right to health care as a human right, it did not become a real constitutional right in South Africa until the Supreme Court clearly explained what it meant and what must be included in it.<sup>413</sup>

Moreover, courts are not only responsible for ensuring that the right to health care is provided under law, at the level required by the law, but they also have to guarantee that the principles of human rights such as equity, non-discrimination and participation are fully respected and adhered to in the implementation of this right.<sup>414</sup> A good example of this comes from the judges of the Inter-American Court, which have held that in regard to the right to life the obligations of the state are not only negative; the state is also required to take positive action which is essential for the protection and implementation of the right to life, including the right to health care.<sup>415</sup>

Another important role that courts, especially supreme courts in some countries, can play, in terms of economic and social rights including the right to health care, is to ensure that they are seen as an aspect of constitutional rights and, therefore, part of the state's fundamental obligations to its citizens, which is where they belong.<sup>416</sup>

To conclude, recognising the justiciability of the right to health care enables us to attain several goals. Firstly, clarification of the nature of the right to health care can ensure that it is regarded as a claim right. The right to health care would then be seen as a positive legal obligation that states have to deal with regardless of resources. Secondly, in terms of

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<sup>411</sup>Yamin, "The Right to Health under International Law and Its Relevance to the United States." 1156

<sup>412</sup>Sections 27 (1) (a), (b) &(c); Section 28 (1) (c) and Section 35 (2) (e) of the Constitution of the Republic of South Africa, Act 108 of 1996

<sup>413</sup>Soobramoney v Minister of Health, KwaZulu-Natal 1998 (1) SA 765 (CC) paras. 28 also Minister of Health v Treatment Action Campaign 2002 (5) SA 721 (CC) para. 99 (S. Aft.).

<sup>414</sup>Yamin, "The Right to Health under International Law and Its Relevance to the United States." 1157

<sup>415</sup>A.E. Yamin, "Not Just a Tragedy: Access to Medications as a Right under International Law," *BU Int'l LJ* 21(2003). 109

<sup>416</sup>.Cassel, "Right to Health Care, the Social Contract, and Health Reform in the United States." 56-60

human rights, a justiciable right to health care would also mean that courts can extend their protection to the right, even if this requires the use of other rights, such as the right to life. Further, under constitutional and international human rights law, courts could institute the necessary steps towards implementation of the right to health care in reality.<sup>417</sup> Finally, and most importantly, recognising the right to health care as a justiciable right would facilitate understanding of its core content and judicial decisions could strike an appropriate balance between individuals' rights and states' duties in regard to health care issues.

A workable and effective human right to health care will not exist unless it is recognised as a legally justiciable right. Although recognising a justiciable right to health care will increase the opportunity to clarify and explain what the right to health care means, this raises the question of what should be included in it. The following section will attempt to show what the right to health care should include and why it cannot include everything. In Chirwa's words, "The right to health is justiciable directly and indirectly through other rights and generates three levels of duty on the state".<sup>418</sup> In the following chapter, the content and implications of recognition of a full right to health care will be considered with specific reference to the situation in Libya, a rich, but developing, country.

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<sup>417</sup>Chirwa, "Right to Health in International Law: Its Implications for the Obligations of State and Non-State Actors in Ensuring Access to Essential Medicine." 565

<sup>418</sup>Ibid. 565

# **Chapter III: The Right to Health**

## **Care in Libya**

### 3.1 Introduction

In the previous two chapters, the definition of a right to health care was proposed and its actual and potential legal status was examined. At this stage, consideration will be given to the status of this right in Libya and how it is approached by the Libyan authorities. It is important to note that this task, however important, is problematic because of the lack of court judgements and academic discourse on this topic. Since information is difficult to obtain,<sup>419</sup> it will be necessary to rely on international sources and to consider how they may be extrapolated into the Libyan context, using such information as has been obtained from the Libyan Ministry of Health.

Additionally, it is necessary to note also that most of the research for this chapter was completed before the overthrow of Colonel Gaddafi's regime in 2011. As a result of the situation in Libya, governmental websites and official documents have been destroyed or are missing, some of which are referred to in this chapter. Despite the current problems in Libya, the hope for better health care exists as the National Transitional Council (NTC) has emphasised that the state is responsible for providing health care services to all its citizens.<sup>420</sup> Until reform in Libya is complete, however, it will be necessary to analyse how things were before the revolution. In what follows, the present tense will often be used although, of course, the system is currently under review.

The first section of the chapter will briefly review the health care system in Libya in order to contextualise the discussion, and will consider what status - if any - the right to health care appeared to have. The second section will focus on the justiciability of the right to health care in Libya and will evaluate how the courts, including the Supreme Court, have approached this right. It will be necessary, therefore, to provide a brief description of the Libyan legal system and to highlight the functions of the Supreme Court before examining some examples of cases relating to the right to health care. This discussion of the attitude of Libyan courts will highlight the problems that exist in terms of the implementation of the right to health care proposed in this thesis. In the third section, Libya's international commitments will be discussed at both African and international levels. As a member of the African Union and the United Nations, Libya has ratified and committed itself to

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<sup>419</sup> Daniel Yergin Michael Porter, *National Economic Strategy, an Assessment of the Competitiveness of the Libyan Arab Jamahiriya* (Monitor Group, the General Planning Council of Libya, 2006). 109

<sup>420</sup> National Transitional Council, Constitutional Declaration, Article 8

several international declarations and conventions in which health care (however described) is specifically mentioned. Thus, the responsibilities of the Libyan authorities to vindicate this right will be addressed, considering both the African human rights system and the United Nations human rights system. Finally, it is important to analyze what mechanisms are available to Libyan citizens to challenge the decisions of internal authorities, including the courts, before external bodies such as the African Court of Justice.

## **3.2 Domestic Situation of the Right to Health Care in Libya**

Health care has been at the top of the government's agenda since Libya became an independent state in 1951 following the decision of the United Nations' General Assembly in 1949.<sup>421</sup> At that time, and before the discovery of oil, Libya was one of the poorest countries in the world and the United Nations tried to deliver some of the elements that were essential for the improvement of living standards in the country, such as administrative advisors, health workers and equipment.<sup>422</sup>

For the purpose of this thesis, it is necessary to discuss briefly the domestic state of health care in Libya. It will, however, be neither possible nor necessary to go into any great depth on this topic, as the aim is to address what the proposed right to health care means in the Libyan context. As has already been said, this is a difficult task as there is little literature available, especially in English. The discussion, however, will use two main sources; firstly, documentary material that has been written about this issue in Arabic or in English and secondly, an analytical explanation of the health legislation and regulations that relate to health and health care.

### **3.2.1 A Brief Review of the Libyan Health Care System**

In Libya's health care system the main provider of health services is the public health sector. All citizens are entitled to receive health care services free of charge. A decentralized structure is adopted at almost all levels of the health care service.

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<sup>421</sup> General Assembly, Question of the disposal of the former Italian colonies, Fourth session, 1949 A/RES/289 (IV), R.B. St John, *Libya: Continuity and Change* (Routledge, 2011). 34-37, D. Vandewalle, *A History of Modern Libya* (Cambridge University Press, 2006). 39

<sup>422</sup> United Nations, Yearbook of the United Nations, Office of Public Information, New York, 1950, 345-47, General Assembly, Economic and Financial Provisions relating to Libya, Fifth session, 1950 A/RES/388 (V), St John, *Libya: Continuity and Change*. 38

Despite guaranteed free health care services, Libya has adopted a mixed system in recent years, which allows both public and private sectors to provide health care services although the private health care sector only plays a limited role. Like other countries, Libya has adopted different visions of its health care system depending on the availability of resources, the political agenda and legal developments. These key elements have changed from time to time and have, therefore, affected health care provision in Libya. To understand the changes and developments that have occurred to the Libyan health care system, it is important to divide the health care system into several parts according to its history. The Libyan health care system can be divided into the following periods.

### **3.2.1.1 Health Status from 1951 - 1969**

In 1951 Libya became an independent country following the UN General Assembly decision made in 1949 which declared that Libya should be an independent country within two years.<sup>423</sup> Although it was one of the world's poorest countries at that time, health matters were nonetheless at the top of its agenda.<sup>424</sup>

The Libyan constitution makes health care the shared obligation of the federal government and the local authorities in the states. In terms of health related matters, the federal government and the government of each state are supposed to coordinate with each other.<sup>425</sup> Libya took fundamental steps to organize its internal health care provisions, first by establishing the Ministry of Health as the formal body that is responsible for health care services in the country. Secondly, health related legislation was adopted in both 1956 and 1958.<sup>426</sup> Moreover, with the aim of achieving full cooperation and coordination between the Ministry of Health and local authorities, Libya established the Higher Advisory Council which comprised the Minister of Health and the managers of public health bodies at local and national levels.

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<sup>423</sup> For more details see modern Libya online at [http://ourworld.compuserve.com/homepages/dr\\_ibrahim\\_ighneiwa/istiklal.htm](http://ourworld.compuserve.com/homepages/dr_ibrahim_ighneiwa/istiklal.htm) accessed on 21/02/09, Dirk Vandewalle, A History of Modern Libya, Cambridge Press, 2006, 39-40

<sup>424</sup> For more details on the health status in Libya in those days see H. H. Thomas, Libya, overseas economic surveys, December 1955, The Board of Trade, Commercial Relations and Exports Department, pp 32- 34

<sup>425</sup> Constitution of Libya, 1951, article 38 amended by Law No 1/1963 in Gazette, Vol, 1, No 1,27/04/1963, Ministry of Justice

<sup>426</sup> The Gazette of the United Kingdom of Libya, Public health law no 69/ 1958, year 8, No 11, issued on 25/08/1958, 16

### 3.2.1.2 Health Status from 1969 - 1980

In 1969, a coup by the army against the King began a new era in the history of the country.<sup>427</sup> In article 15 of the Constitutional Proclamation issued by the leadership council of the revolution to replace the constitution of 1951 it was stated that “[h]ealth care is a right guaranteed by the State through the creation of hospitals and health establishments in accordance with the law.”<sup>428</sup> With regard to health care, the leaders of the revolution issued new regulations for the Ministry of Health in 1970 and, perhaps most importantly, Libya acceded to the International Covenant on Economic, Social and Cultural Rights on 15 May 1970. As a result, Libya was committed to take all necessary steps to fulfil its obligations under article 2 of the ICESCR.

In 1973, and in accordance with this covenant, the first comprehensive Libyan health law was issued by the government.<sup>429</sup> Health law No 106/1973 covered all of the major areas of health and health care, including public health, medical practice, curative and preventive programmes, the drug trade, blood bank and food control. The first article of this law clearly states that health and medical care are everyone’s right and should be guaranteed by the government of the state. This statement was a significant development in the legal and political culture of Libya as this was the first time that health care appeared as a human right in modern Libya. However, this legislative development was not followed by effective action by the authorities such as the judiciary and the government. For example, as will be seen in the coming sections, judicial review does not deal with health care within the context of human rights. However, health services were included in the first three-year National Transformation Plan (1973-1975) which confirmed that access to health services was the right of every citizen, although Libyan politicians seem not to have understood the full consequences of accepting this.

### 3.2.1.3 Health Status from 1980 - 2008

During this era, the health sector was unstable both politically and legally. However, there was an improvement in terms of health care planning. In 1981, a national health strategy

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<sup>427</sup>E. Paoletti, "Libya: Roots of a Civil Conflict," *Mediterranean Politics* 16, no. 2 (2011). 315

<sup>428</sup> Constitutional Proclamation, 1969, available online at <http://www.servat.unibe.ch/icl/ly00000.html> accessed on 22/03/2009

<sup>429</sup> Libyan Gazette, Legislation No 106 Of 1973, Vol 12, No 6 in 13/12/1973

was adopted by the Libyan authorities. This was a part of a Five-Year Plan (1981-1985) which aimed to provide for comprehensive socioeconomic development in the country.<sup>430</sup>

This national health strategy was the basis of the primary health care strategy which was adopted in 1994; a strategy which, somewhat belatedly, sought to fulfil the goals of the World Health Organization's (WHO) commitment to, "Health for all by the year 2000" which was outlined in the Declaration of Alma Ata in 1978.<sup>431</sup>

However, the administrative system of the Health Ministry did not have a sound basis. For instance, the Ministry of Health was completely removed from the Cabinet in 2000 when the Libyan General People's Congress (Parliament) strengthened the process of decentralization, ending most central health authority functions and giving them to local health authorities in each municipality. This proved to be problematic, particularly since there was a lack of human resources and medical supplies in some municipalities.<sup>432</sup>

In 2006, the Ministry of Health was re-established, but with a remit that covered not only health care matters but also environmental issues. This arguably could have diminished its capacity to focus on health care (even though environment clearly plays a role in health). There were also structural problems. The country was divided into 22 regions (Shabiat), which meant that there were 22 secretariats of health at the regional level who worked under the supervision of the Health Minister. Because of this cumbersome structure, during this era health care was not delivered as it should have been and citizens were unable to obtain a good standard of health care. At the same time, the private health care sector started to enter the field in Libya, although the public health sector remained the main health service provider.<sup>433</sup>

To summarize, the health care sector in general faced several problems which were clearly listed in the WHO report on Libya in 2006.<sup>434</sup> The history of health care provision in Libya covers only modern times and is short. However, it is important to note several of its

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<sup>430</sup>The WHO Regional Office for the Eastern Mediterranean. 2007, health system profile, Libya, Cairo, 11

<sup>431</sup> WHO, Regional Office for Europe, Declaration of Alma Ata, available at [http://www.euro.who.int/\\_data/assets/pdf\\_file/0009/113877/E93944.pdf](http://www.euro.who.int/_data/assets/pdf_file/0009/113877/E93944.pdf) accessed 25/04/2012

<sup>432</sup>The WHO Regional Office for the Eastern Mediterranean. 2007, health system profile, Libya, Cairo, 38

<sup>433</sup>The WHO, Ibid, 10

<sup>434</sup> WHO, Country Cooperation Strategy for WHO and the Libyan Arab Jamahiriya 2005-2009, Regional Office for the Eastern Mediterranean, Cairo, 2006, EM/ARD/009/E/R, 7 available on line at [http://www.who.int/countryfocus/cooperation\\_strategy/ccs\\_lby\\_en.pdf](http://www.who.int/countryfocus/cooperation_strategy/ccs_lby_en.pdf) accessed 23/11/2010

characteristics. Firstly, the right to health care is categorised as a legal right. In addition to this domestic provision, the Libyan government is obligated under the ICESCR to do its best to provide the highest standard of health care for all citizens. Thus, it is clear that Libya regards health care as a human right and, as a consequence, the judiciary should consider it in that way, potentially facilitating its vindication should the executive branch fail to do so. Secondly, the limited role played by the private sector is controlled by economic rather than human rights considerations.<sup>435</sup> Thirdly, any improvement in health care in Libya requires stability in administrative arrangements, financial support, the legal framework and health policies; otherwise, Libya cannot provide the right to health care for its citizens as is required under national and international law. Arguably, the need for stability may require that health care should be dealt with independently from other areas. In other words, the combination of health care and other sectors such as the environment or social welfare may damage health care services rather than producing benefits.

The major components of Libya's current health care policy are based on the Health Act No 106 of 1973 and the decision of the General People's Committee No 24 of 1994 which adopted the National Strategy's commitment to providing health care for all.<sup>436</sup> This decision has played an essential role in elaborating the meaning of the right to health care in the Libyan system. Looking at decision No 24, one can see that it copied the Declaration of Alma Ata which was adopted by the WHO in 1978. Implementing the strategy of Alma Ata divided the health care system into three levels.<sup>437</sup> The first level is primary health care, encompassing primary health care units and centres, communicable diseases centres and polyclinics. The second level is secondary health care, comprising general hospitals and rural hospitals. The third level is tertiary health care which includes specialized hospitals. Together, the Health Act and decision No 24 have legally established the concept of a right to health care but the question remains as to what this right was taken to mean and whether it was both workable and attainable.

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<sup>435</sup>It is controlled by the law of practicing economic activities No 9/1992 and its emendation by the law no 21/2000, it is also clear that the health care cases were not considered as human rights or even legal rights issues by domestic courts but political issues that the government has boarder discretion authority limited by available allocation resources.

<sup>436</sup> The Secretariat for The General People's Committee, Health Decree No 24/1994 'National Health Strategy'-Health For All by the Year 2000\_ 19/01/1994

<sup>437</sup>EMRO, Health System Profile, Libya, Regional Health Systems Observatory, World Health Organization,2007,30 available online at <http://gis.emro.who.int/HealthSystemObservatory/PDF/Libya/Full%20Profile.pdf> accessed on 20/07/2011

### 3.3 The Meaning of the Right to Health Care in the Libyan Health Care System

Answering the above question requires a deep understanding of the health care system in Libya, which is rather complicated. On the one hand, it is clear that the right to health care is treated as a human right in Libya in accordance with article 1 of the Health Act which states that “medical care and health care is a duty of the state and they are guaranteed by the government to all citizens”.<sup>438</sup> The right to health and medical care is described in article 2 of the Health Act which outlines the responsibilities of the Health Ministry as follows: the Ministry of Health supervises public health, preventive health and medical treatment. It is also responsible for running treatment institutions and pharmaceutical facilities. Finally, the Ministry of Health has responsibility for monitoring the circulation of medicines and the practice of medicine.<sup>439</sup> On the other hand, this legislation, unlike other Libyan laws, does not include any legal mechanism that can make this legal right justiciable in reality. Although it contains a special chapter imposing criminal charges and sentences on anyone who violates its rules, this system was designed to cover any violation of the law by citizens, but not the authorities of the state. This clearly makes vindication of the right against the state impossible.

Moreover, the meaning of the right adopted by the Libyan health legislation was, until the 1980s, similar to the international concept of health that was described in Chapter 1. Despite the fact that the Libyan legislation refers to the right to health care, it is likely that there was some confusion between the phrase ‘the right to health care’ and ‘the right to medical care’, both of which are stressed in article 1 of the Health Act. Arguably, however, there was no need to include the phrase ‘the right to medical care’ within the right to health care. The latter, as has already been argued, includes the former.<sup>440</sup>

The problems with using the international phrase ‘the right to health’ which have been discussed earlier are reflected in the implementation of the health care provision in Libya even to the present time. However, since the 1980s Libya has begun to adopt a new theoretical approach that focuses on the right to healthcare. For example, environmental

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<sup>438</sup> Libyan Gazette, Vol: 12, No: 6, Health Act No 106 of 1973, 13/12/1973 article 1

<sup>439</sup> Article 2 of the Health Act No 106 of 1973

<sup>440</sup> Toebes, *The Right to Health as a Human Right in International Law*. Ssenyonjo, *Economic, Social and Cultural Rights in International Law*. 325

protection and public hygiene were removed from the Health Act 1973 and were the subject of separate and specific legislation. This new trend has brought policy closer to the proposed right to health care argued for in this thesis.<sup>441</sup> However, in spite of this, the Ministry of Health still has responsibility for environmental health which impacts on its consideration of health care.

According to Porter and Yergin, the Libyan health system is so complicated that no one can make a proper evaluation of it.<sup>442</sup> For example, they noted that health statistics generally show that Libya spends much less on health care when contrasted with the Middle East and North Africa (MENA) and, of course, this expenditure is far behind the averages in countries such as the UK or Norway.<sup>443</sup>

This raises the question as to whether or not the meaning of the right to health care contained in the Health Act is compatible with the concept of the right to health care argued for in this thesis. However, it has been said that spending does not always produce good health care services in a state. It is important as an indicator of the consideration given to the health care sector and also in a country like Libya there is an assumption that, due to its economic level, resources are readily available. Thus, as result, citizens must have a high level of health care services.

### **3.4 The Concept of Right to Health Care in Libyan Health Law**

Although, the right to health care in the Libyan Health Act has some similarities to the right argued for in this thesis, there are also differences. As has been seen, the proposed definition of the right to health care is intended to clarify some of the confusion around what is meant by the right. While it is not claimed that this right is a perfect solution to the problems of definition, it can play an important role in that clarification which, it has been argued, is important for both its content, its scope and how it may be vindicated.

In terms of the differences, the original Libyan Health Act seemed to rely on the international concept of ‘a right to health’ which, it has been argued, is an inappropriate

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<sup>441</sup> In the 1980s the environmental protection law and the public hygiene law were issued by the GPC. Thus, they were no longer part of the Health Act No 106.

<sup>442</sup> Michael Porter, *National Economic Strategy, an Assessment of the Competitiveness of the Libyan Arab Jamahiriya*. 111

<sup>443</sup> Ibid. 110, WHO, country cooperation strategy at a glance, Libya, available at <http://www.who.int/countries/lby/en/> accessed on 18/04/09

and sometimes unhelpful term. Thus, Libyan health law remains vague as to what it is attempting to achieve and protect, making it difficult to identify the core of the right and to ensure that it can be attained. Another variation between the author's definition of the right to health care and its meaning in Libyan health law is related to the word 'right' which means, at the most basic level, that "the government guarantees something to everyone".<sup>444</sup> Although both texts used the word 'right', the Health Act does not clarify how this is to be achieved and contains no mechanism for achieving it. In particular, there is no mechanism that permits citizens to challenge a perceived failure by the government to provide the resources necessary for implementation of the right. In other words, at present the Health Act does not envisage the right to health care as a justiciable right, despite the argument in this thesis that this is an essential component of the right. As underlined by Lynch, the justiciability of a human right is the most significant instrument preventing infringement.<sup>445</sup>

One similarity, however, is that both in the Libyan Health Act and in the right proposed in this thesis lies acceptance that there is a 'right' that requires governments to act to fulfil it. The right, then, is more than a moral commitment and requires legal status, imposing obligations on the state. Another similar feature between the right to health care in Libyan health law and in the proposed definition in this thesis is that they both address the main components of health care. In addition, the separation of environmental protection,<sup>446</sup> public hygiene<sup>447</sup> and the regulation of the use of radiation in medicine<sup>448</sup> from health care in general make it more likely that the right to health care will be clarified. This may make fulfilment of the right to health care more feasible at the national level, but the administrative and political framework in Libya makes dealing with this complex. Administrative and political action on health care still appears to be more closely linked to international concepts, rather than to the right proposed here. Thus, the concept of health care that has been adopted by the Libyan government is different at its core from that argued for in this thesis.

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<sup>444</sup>C.L. Engelhard and M.P.A.A. Garson Jr, "The Right to Health Care and the Role of Government in Health Policy," *Medicine* 18, no. 1-2 (1992).

<sup>445</sup>Philip Lynch, "Harmonizing International Human Law and Domestic Law and Policy," *Melbourne Journal of International Law* 7, no. 1 (2006). 228

<sup>446</sup> Protection of environment Act No 7 of 1982, Gazette, No 24, 1982, amended by protection and improvement of the environment Act No 15 of 2003, Gazette, No 4, 16/08/2003

<sup>447</sup> Public Hygiene Act No 13 of 1984, Gazette, No 17, 16/06/1984

<sup>448</sup>the regulation of the use of radiation in medicine Act No 2 of 1982, Gazette, No 10, 06/04/1982

### **3.5 Justiciability of the Right to Health Care in Libya**

Despite the legislative roots of the right to health care in Libyan law which were investigated in the previous section, courts can only deal with any dispute as long as there is a legal basis for it. To understand the relationship between citizens and the state and to explore whether human rights can be justiciable under the Libyan legal system, it is necessary to describe that system with particular emphasis on the role of the courts. In this section, therefore, the focus will be on the role of Libyan judicial authorities in underscoring the importance of human rights; in this case, the right to health care. But before that discussion, it may be helpful to provide a brief overview of the Libyan legal system. This will assist in understanding how the Libyan courts, and particularly the Supreme Court, have treated lawsuits concerning health care services. The problems that face the implementation of this right at a national level will be explained and the role of the Supreme Court will be discussed. As a result, the justiciability of the right to health care in the light of the Libyan domestic situation will be clarified.

#### **3.5.1 A Brief Description of the Libyan Legal System**

As is the case in other North African and Middle Eastern countries, the Libyan legal system was shaped by its period as a European colony. After independence, the Libyan authorities used an expert, Abd-al-Razzeq al-Sanhuri, to assist in the development of new laws and to create the legal system for the new-born country. Mr al-Sanhuri copied the Egyptian Civil Code which was based on the French Civil Code. As an Islamic country, the Libyan Civil Code has also adopted some principles of Sharia law but, in general, it has followed the traditions of European law.<sup>449</sup>

The Libyan Civil Code is the main source of law in the Libyan legal system. In its first article it describes the formal sources of the law - legislation, principles of Islamic law, custom, the principles of natural law and the rules of equity. According to this article, when judges are not able to apply the rules of one of the primary or formal sources of the law, they have permission to use previous judicial decisions (case law) and the thoughts and doctrines of distinguished jurists as informal sources of law.<sup>450</sup>

Because of the European influence, the Libyan legal system was based on the principle of separation of powers. As De Montesquieu put it, separation of powers means the power of

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<sup>449</sup>Waniss A. Otman and Erling Karlberg, *The Libyan Legal System and Key Recent Legislation* (Springer Berlin Heidelberg, 2007). 63

<sup>450</sup>Libyan Civil Code of 1953, article 1

the state should not be controlled by a specific body, but it should be spread between all the arms of the state in a way that gives each branch its independent powers and areas of responsibility.<sup>451</sup> The point here is that the state must be divided into three estates: executive, legislature and judiciary.<sup>452</sup> Thus, the judiciary is not allowed to interfere in executive or parliamentary work or political issues.

Libya adopted a similar legal structure after independence in 1951. In the Libyan constitution, there were three branches: government, parliament, and judiciary.<sup>453</sup> In 1969, Libya took a slightly different direction. The council leader of the revolution decided to take all three areas under their direct control; thus the council was able to take upon itself both legislative and executive powers. The constitutional declaration of 1969 stated that:

The Revolutionary Command Council constitutes the supreme authority in the Libyan Arab Republic. It will exercise the powers attached to national sovereignty, promulgate laws and decrees, decide in the name of the people the general policy of the State, and make all decisions it deems necessary for the protection of the Revolution and the regime.<sup>454</sup>

In 1977, the State of Masses was declared in Libya as a new political system. The State of Masses, as Gaddafi described it in his Green Book, is based on direct popular democracy which consists of the twin pillars of people's committees and people's congresses.<sup>455</sup> The people's congresses are equivalent to a legislative body in traditional political systems and the people's committees operate in the same way as an executive branch. Although the

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<sup>451</sup> There are many academic writings on this subject, for example see MoNTESQUIEU, *THE SPIRIT OF THE LAWS*, BOOK XI, ch.6, C. Saunders, "Separation of Powers and the Judicial Branch," *Jud. Rev.* 11(2006). T.S. Clark, "The Separation of Powers, Court Curbing, and Judicial Legitimacy," *American Journal of Political Science* 53, no. 4 (2009). T. Campbell, *Separation of Powers in Practice* (Stanford Law and Politics, 2004).

<sup>452</sup> Campbell, *Separation of Powers in Practice*. Clark, "The Separation of Powers, Court Curbing, and Judicial Legitimacy."

<sup>453</sup> Constitution of Libya, available online at [http://ourworld.compuserve.com/homepages/dr\\_ibrahim\\_ighneiwa/51const1.htm](http://ourworld.compuserve.com/homepages/dr_ibrahim_ighneiwa/51const1.htm) accessed on 23/04/2009.

<sup>454</sup> Libyan constitutional declaration of 1969, article 18 available online at <http://www.servat.unibe.ch/icl/ly00000.html> accessed on 25/04/2012, St John, *Libya: Continuity and Change*. 54-55, Vandewalle, *A History of Modern Libya*. 82

<sup>455</sup> About the political system of Libya since the revolution see L.C. Harris, *Libya: Qadhafi's Revolution and the Modern State* (Westview Press, 1986). 63-67. see also S.G. Hajjar, "The Jamahiriya Experiment in Libya: Qadhafi and Rousseau," *The Journal of Modern African Studies* 18, no. 2 (1980). 181-200

judiciary was reorganized by the new organisational system, the judicial branch structurally has not been affected as significantly as the other branches.

### 3.5.1.1 The Legislative Machinery

As has been already mentioned, the people's congresses play the role of the legislative body. According to Gaddafi's third way theory, all Libyans over 18 years old are lawmakers and participate in lawmaking. It is evident that this method is complicated and is not useful or practical when compared to other systems in the world.

From the perspective of the Green Book, direct democracy is the basis for the political system in Libya. Theoretically, all citizens should contribute to making state policy. In practice, however, it seems impossible to ensure such participation and the Libyan authorities have therefore designed a new way of making law.<sup>456</sup>

There are two main steps to making law in Libya.<sup>457</sup> First, there is the Basic People's Congresses (hereafter referred to as BPsC) which are the main players in the Libyan political system. The function of the BPsC is to propose, review and enact laws. The BPsC consists of all citizens who are 18 years old and over and divides them into small groups depending on geo-demographic factors. There are about 461 Basic People's Congresses in Libya. Each one is empowered to select its secretariat and people's committee. In addition, the heads of the secretariat of the Basic People's Congress and the secretary of the people's committee serve to convey the decisions of the Basic People's Congress to the General People's Congress (hereafter referred to as the GPC).<sup>458</sup>

The GPC is at the pinnacle of the legislative machinery in Libya. All the Basic People's Congresses are associated with enacting laws and formulating public policy, as well as declaring war or ratifying international agreements. The GPC consists of twelve secretaries including the General Secretary,<sup>459</sup> who is theoretically the Head of State. The GPC also elects the General People's Committees which are equivalent to the executive arm in more traditional systems. It is also authorized to nominate the head of the National Oil

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<sup>456</sup>Paoletti, "Libya: Roots of a Civil Conflict." 317

<sup>457</sup>Cholmeley-E, F. Kelbash, and E Mukhtar, *Libya: A Guide to Commercial Law, Banking Law & Accounting* (GMB Pub., 2008). 2-3

<sup>458</sup>Paoletti, "Libya: Roots of a Civil Conflict." 317

<sup>459</sup> Decision of the General Secretariat of the General People's Congress No 4 of 2009 on rebuilding the General Secretariat of the General People's Congress on 04/03/2009, available online at <http://www.npc.gov.ly/doc/news/law4444.pdf>,<sup>1</sup> in Arabic accessed on 30/07/2009

Corporation, the governor of the Libyan central bank, and the heads of other national institutions, such as the president and members of the High Court.<sup>460</sup>

### 3.5.1.2 Executive Authority

In 1951, Libya was recognised as an independent state - The Kingdom of Libya - by the United Nations.<sup>461</sup> The Libyan Kingdom was run by a Council of Ministers, led by the Prime Minister who was chosen by the King.<sup>462</sup> Since 1969, Libya has been a republic following the revolution led by Muammar Gaddafi who changed the country's official name to the Libyan Arab Republic.

Between 1969 and 1977, the Revolutionary Command Council (RCC) was responsible for both legislative and executive functions.<sup>463</sup> In 1977, Gaddafi proposed a new political theory - the so-called the third way. After 1977, executive authority in Libya seemed to be different from the governments in other countries; in reality, however, the executive body was equivalent to the administrative branch of the government in Western Countries.

According to the Green Book, the Libyan people have the right to govern the country directly through the General People's Congress, which is the legislative branch, and the General People's Committees. Although the General People's Congress is elected by Libyan citizens, the members of the General People's Committees are usually chosen by the Congress. When the Congress works on the formation of the General Committees it will name the General Secretary of the General Committee who will then work as the Prime Minister to the government.

In general, the key element of government in Libya is that the government ministers have no right to create or come up with new plans and policies other than those that are adopted by the Libyan people and articulated by the Congress, which issues them in legislation or via decisions which each General Committee (ministry) should follow and implement. The General Committees are formed at local, regional and national level and each national General Committee comprises members who also serve at local and regional level. For example, the General People's Committee for health and the environment included in its

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<sup>460</sup>Cholmeley-E, Kelbash, and Mukhtar, *Libya: A Guide to Commercial Law, Banking Law & Accounting.*, 4

<sup>461</sup>K.T. Szabó, *Libya and the Eu* (Central European University, Enter for EU Enlargement Studies, 2006). 8

<sup>462</sup> Kingdom of Libya, Wikipedia, available at [http://en.wikipedia.org/wiki/Kingdom\\_of\\_Libya#Council\\_of\\_ministers](http://en.wikipedia.org/wiki/Kingdom_of_Libya#Council_of_ministers) accessed on 07/08/ 2009

<sup>463</sup>C.R. Black, "Deterring Libya: The Strategic Culture of Muammar Qaddafi," (DTIC Document, 2000). accessed 07/08/2009 online at <http://www.au.af.mil/au/awc/awcgate/cpc-pubs/black.pdf>

membership the general secretaries for health and environment at both local and regional levels.<sup>464</sup>

The General People's Committees have the right to propose new legislation and establish the policies and strategies that allow them to be implemented. In accordance with article 11 of Act 1/2008, the responsibility of each General People's Committee is regulated by several conditions. Firstly, the Committee has to follow the public policy, legislation and decisions adopted by the General People's Congress. Secondly, they cannot change or make law.

At the domestic level, the administrative branch can improve the quality of health care and its delivery to citizens. In addition, it is permitted to draw up the national health care strategy and how it is to be implemented.<sup>465</sup> For example, and as stated by the courts in Egypt (bearing in mind that the Egyptian legal system is the historical source of the Libyan legal system) the Ministry of Health can propose and enforce health regulations in emergency care. According to the Administrative High Court in Egypt, the Ministry of Health has the power and the competency to undertake all necessary steps to prevent and block the spread of any disease, including the power to quarantine individuals and to destroy property.<sup>466</sup> Finally, the executive body has the right to propose new health care legislation when this is necessary.

At the international level, the General People's Committees, including the General Secretary (Prime Minister), are responsible for signing and making international agreements on behalf of the state of Libya, but such agreements must be endorsed by Congress before Libyan authorities are bound by them. In other words, international agreements constitutionally do not enter into force and become part of domestic law until they are incorporated into national law by parliament. In respect of international cooperation, article 47 of the Health Act of 1973 required the Ministry of Health to cooperate positively and directly with the World Health Organization.<sup>467</sup> For example, the Ministry of Health is obliged to update appropriate information on international health

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<sup>464</sup> See article 11 of the Basic People's Congresses operating and systems act No 1 of 2008 access at 07/08/2009 online in Arabic at [http://www.gpc.gov.ly/myfiles/2009/pdf/reprodoc/law\\_1\\_1375.pdf](http://www.gpc.gov.ly/myfiles/2009/pdf/reprodoc/law_1_1375.pdf)

<sup>465</sup> The WHO, Regional Office for the Eastern Mediterranean, Regional Committee for the Eastern Mediterranean, the role of the government in health development, July 2006, EM/RC53/Tech. Disc.1, available <http://gis.emro.who.int/HealthSystemObservatory/Workshops/WorkshopDocuments/Reference%20reading%20material/The%20role%20of%20governmentEMRC53TECHDISC01en.pdf> accessed on 26/04/2009, 4-8

<sup>466</sup> Health Act No 106 of 1973

<sup>467</sup> Health Act No 106 of 1973

status. It is also required to make announcements about any health risk which it views as a threat to other international members. In general, the Health Ministry is the arm of the government with responsibility for improving, protecting and collaborating on health care matters within and without the country.<sup>468</sup>

The General People's Committee is essentially the equivalent to the Council of Ministers in Western states, and hypothetically leads the country with the GPC. In practice, there is a belief that the real head of state is Gaddafi and all of these bodies - namely the GPC, BPsC and the General People's Committees - are part of a political agenda that is similar to that of a third world country.<sup>469</sup> Whatever weaknesses the Libyan system has, it seems that this 'third way' can offer opportunities for participation in health care decision-making as required by international organizations. Such participation will, in theory, allow people everywhere in Libya to participate in decisions relating to their health care. As part of the procedures of the legislative branch, Libyan citizens could play a key role in underscoring the importance of the right to health care and in strengthening its legal status.

### **3.5.1.3 Judicial Machinery**

At the outset, it is important to note that the courts in Libya have indirectly influenced political change since Libya's independence. Because, according to the Libyan Constitution of 1951, courts are independent, they are the only legal body that can adjudicate on issues concerning people's rights. The judiciary is responsible for reviewing the legality of legislation and the decisions made by the other two branches of the state as well as making judgments about any disputes that arise between them or between citizens. As Mukhtar said, the aim of judicial decisions is expected to be the protection of the principles of the community as well as the rights, dignity and freedom of the individual from infringement by others, including the state. As independent bodies, courts have the potential to be the main way through which the rights and duties of individuals are balanced against the government.<sup>470</sup>

Two important points need to be made about the Libyan judicial system. The first is that judges are required to interpret the law in accordance with article 1 of the Libyan Civil Code, which classifies the sources of law into two categories. Firstly, formal sources which comprise legislative provisions, Islamic principles, custom, and the principles of natural

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<sup>468</sup> The WHO international health regulations 26, 8-9

<sup>469</sup> Such a view is mentioned in most Western states' reports about Libya especially those reports written by the ministries of foreign affairs, for instance, the report of the Secretary of State in the USA, Libya, background note, available online at <http://www.state.gov/r/pa/ei/bgn/5425.htm> accessed on 26/04/2009

<sup>470</sup> Cholmeley-E, Kelbash, and Mukhtar, *Libya: A Guide to Commercial Law, Banking Law & Accounting*.

law and the rules of equity. The second category includes informal sources of law, including judicial decisions, the thoughts and doctrines of eminent Islamic jurists and the law guiding judicial decision-making.<sup>471</sup>

The second important point is that the Libyan judicial system works in a hierarchical manner (vertically) and each level is divided in light of the subject of the case or its parties (horizontally). In other words, the courts are divided into different levels. However, there is only one Supreme Court. Thus, there are four types of courts in Libya: civil courts, administrative courts, criminal courts, and personal status courts.<sup>472</sup> These courts have been designed in a diversity of levels. These levels depend on both quantitative and qualitative approaches. For instance, criminal cases are supposed to be brought to criminal courts and civil cases to civil courts, taking into account the amount of money involved in each particular case which might direct the applicant to a First Instance court or to a Summary Court.

At the first level, there are the Summary Courts. These are usually located in small towns and they hear cases of less than 1000 LD value.<sup>473</sup> The Summary Courts are generally led by a single judge. In some cases, claimants can appeal against the judgments of this court to the Courts of First Instance. However, if the judgment of the Summary Court concerned a case whose value was less than 100 Libyan Dinars that decision will be final and there is no appeal against it.

Secondly, there are the Courts of First Instance which are led by three judges. The Courts of First Instance are split into a variety of chambers which are based on the subject matter of the case; that is, whether it is a civil, criminal, and commercial or a personal status case. For example, there is a Court of First Instance for civil cases and another Court of First Instance for criminal cases.<sup>474</sup>

The competency of the Court of First Instance can be explained as follows. Firstly, as a court of first instance, it has jurisdiction over all cases that are valued at more than 1000 LD and also over disputes about property. Secondly, as an appeal court, it can review the

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<sup>471</sup>Civil Code, 1953, United Nations, Great Socialist People`s Libyan Arab Jamahiriya, Public Administration, Country Profile, Division for Public Administration and Development Management (DPADM), Department of Economic and Social Affairs (DESA), 2004, 8 available at <http://unpan1.un.org/intradoc/groups/public/documents/un/unpan023273.pdf> accessed on 25/04/2012

<sup>472</sup>The UN, Economic and Social Council, E/1990/5/Add. 26, 16/02/ 1996, initial reports submitted by states parties under articles 16 and 17 of the covenant, Libyan Arab Jamahiriya, 8

<sup>473</sup>Cholmeley-E, Kelbash, and Mukhtar, *Libya: A Guide to Commercial Law, Banking Law & Accounting*. 14

<sup>474</sup>The UN, Economic and Social Council, E/1990/5/Add. 26, 16/02/ 1996, initial reports submitted by states parties under articles 16 and 17 of the covenant, Libyan Arab Jamahiriya 8, W.A. Otman and E. Karlberg, *The Libyan Economy* (Springer, 2007). 67

judgments of the Summary Courts. According to the civil and criminal procedures' codes, an appeal against the judgments of the Court of First Instance can be heard by the Courts of Appeals.

Thirdly, there are the Courts of Appeals which are located in the main cities of Libya; six in the country as a whole. In general, these courts have jurisdiction to review the judgments of the Courts of First Instance. Moreover, the Courts of Appeals can hear disputes between the government or one of its bodies and an individual or legal person; lower courts have no jurisdiction in such cases. Judgments of the Court of Appeals can be reviewed by the Supreme Court, as will be explained in the next section.

In regard to the Courts of Appeal, it is important to note that although these courts work to review the judgments of other courts, such as commercial, civil and criminal courts, in terms of administrative decisions, these courts have also been authorised to review the decisions of the government or its agents by judicial review.<sup>475</sup> In terms of health care services, the Court of Appeal is supposed to play a central role, as most health care in Libya is provided by the public sector. However, as will be seen in the cases discussed below, this has not been the reality. In fact, Libyans have tended to raise health care cases in civil courts seeking compensation for costs if they have already received treatment overseas or seeking to compel the government to cover their expenses for treatment in another country. As will be seen, then, the cases which have reached Libyan courts differ in aim and content from those that are more typical in countries such as the UK.

This can be explained by the fact that, even when the courts are available, they are not used because the fundamental underpinning of health care is so poor within Libya. The preferable alternative has been to seek treatment outside of the country rather than to challenge local provision. In addition, it seems plausible that the (hopefully historical) lack of a culture of human rights in Libya has meant that neither citizens nor courts have approached health care issues from this perspective. These issues will be considered later in the thesis when the implications for the new state of Libya are addressed in more depth.

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<sup>475</sup> Mohammad Alharari, *judicial review of administrative actions in Libyan Law*, 5<sup>th</sup> ed, the University Library Press, 2010, El Zawaya, 40-49, see also article 1 of the Supreme Court Act of 1953 and article 1 of the administrative judiciary Act No 88 of 1971.

## 3.6 The Supreme Court in Libya

The founders of the Libyan legal system established a Supreme Court that is authorized to hear appeals against the judgements of the lower courts and which has the responsibility to protect the rights and values of Libyan society, irrespective of who was the lawbreaker - state or citizen.

In Libya, there is only one Supreme Court and it has the final word in all cases that are heard by it.<sup>476</sup> This Court consists of a number of circuits and each circuit deals with a specific sort of case and is led by a Chief Justice and a number of Justices. In general, a Justice is permitted to participate in more than one circuit.<sup>477</sup> In regard to the Supreme Court in Libya, it is significant for the purposes of this thesis to explain what role the Court can play in the Libyan legal system and the value of its judgments.

### 3.6.1 The Role of the Supreme Court

The role of the Libyan Supreme Court has depended on the legislation that it deals with. For, example, Law No 6 on the Reconstruction of the Supreme Court withdrew the constitutional power of the Court, meaning that it was not able to hear any constitutional case. This negatively affected not only the constitutional theory of the country but also human rights in general. In 1994, the constitutional power of the Supreme Court was re-established by Act No. 17 of 1994.

It must also be understood that the limitations of the Supreme Court mean that the Court is not a 'court of fact' but rather a 'court of law'.<sup>478</sup> Its role can be briefly explained in what follows. Its first aim is to ensure that law is implemented correctly without violation or misapplication and that there has been no error in applying the law in any particular case.<sup>479</sup> In other words, the Court aims to control the application and interpretation of the law as a Cassation Court in a way that unifies the practice of law throughout the country.<sup>480</sup> Its second aim is to end any kind of dispute as to jurisdiction between the courts. Finally, and most importantly, the Supreme Court is responsible for ensuring that all constitutional

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<sup>476</sup> See A. Abutota and J. Zreg, *Libyan Supreme Court, Half a Century of Action*, 1st ed. (Libyan Supreme Court Publications, 2007).

<sup>477</sup> *Ibid.* 28

<sup>478</sup> Cholmeley-E, Kelbash, and Mukhtar, *Libya: A Guide to Commercial Law, Banking Law & Accounting*. 15

<sup>479</sup> *Ibid.* 16

<sup>480</sup> Abutota and Zreg, *Libyan Supreme Court, Half a Century of Action*. 16

rights are protected and that the constitution has not been violated by anyone - including, of course, official bodies.

### **3.6.2 The Legal Value of a Supreme Court Judgment**

Judgments of the Supreme Court have great value in contrast to other legal instruments. According to article 31 of the Law No 6 of 1982, the legal principles identified by the Supreme Court are binding on all courts and other authorities in Libya. In the light of article 31, the decisions of the Court are considered as binding law, regardless of the view of some who have argued that such decisions have moral value rather than legal force.<sup>481</sup> The Supreme Court seems to be empowered not only to apply the law as it has been enacted but also to correct any mistakes that may have occurred during its enactment. In other words, it can scrutinize the legitimacy of any legislation or decision.

It is clear, therefore, that the judgments of the Supreme Court have great influence on the other courts, as well as on other institutions in the country, including governmental bodies. Any legal principle established by the Court must be followed by all public and private bodies and individuals. Given its authority, the Supreme Court clearly has a vital role to play in the protection of human rights, which is of particular importance given that the Libyan constitutional framework is not clear, especially in terms of the concept of human rights. At a the national level, then, the only legal body that can finally resolve human rights disputes between the state and its citizens will be the Supreme Court.

In regard to constitutional competency, the Supreme Court's authority to hear constitutional cases, restored in 1994, means that if the Supreme Court wants to examine a constitutional case, it has to arrange a meeting including all of its chambers.<sup>482</sup> According to Act No 17 and the amendments contained in Act No 8 of 2004,<sup>483</sup> the Court has the power to review constitutional cases raised by individual citizens. As the body with authority for protecting rights in society, the Supreme Court has the power to promote and develop understanding of the meaning of human rights in a way that requires the government to vindicate the rights by implementing its obligations at national level and under international law. Despite the recent attitude of the Libyan Supreme Court, there is theoretically an opportunity for the Court to reduce the gap between the expectations of the citizens in regard to their rights and their concerns when they are not met by state action, in line with the state's domestic and international obligations.

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<sup>481</sup> Ibid. 45

<sup>482</sup> Libyan Gazette, Vol:32, No: 6, 24/03/1994 Amendment Act No 17 of 1994 article 23

<sup>483</sup> Legislations Record (Libyan Gazette), Vol:4, No: 3, 31/03/2004 Act No 8 of 2004 article 1

## **3.7 Health Care Obligations of the Libyan Government**

Legally, health care obligations and commitments in Libya could be derived from two kinds of sources. The first source flows from the international health care commitments that the Libyan government, like other governments in the world, has promised to undertake. These international health care commitments can result from regional agreements such as the African Charter on Human and People's Rights or international agreements such as the International Covenant on Economic, Social and Cultural Rights as will be explained in more detail below.

Another source of health care obligations is national law. The international and national commitments that are made by governments are usually enacted in domestic law which demonstrates the intention of the government to implement them. Following its accession to the ICESCR in 1970, the Libyan government spent three years working to enact a new health law which was issued in 1973. The Government, therefore, is bound by both domestic and international agreements in this area, each of which will be considered in what follows.

This part of the discussion will be divided into two subsections. The first will discuss the foundation of the right to health care in Libyan legislation, including the Constitution. The second subsection will focus on how the courts, including the Supreme Court, have dealt with this right. Both subsections will highlight how these bodies have defined the right and underscore whether these meanings meet the terms of the right to health care as proposed in this thesis.

### **3.7.1 The Right to Health Care in Domestic Law**

Since independence, health care has been at the top of the agenda of the Libyan authorities; indeed, it is declared by the Constitution to be a constitutional right. In relation to health care, several pieces of legislation were enacted but it is noteworthy that such legislation did not treat health care as a human right. In fact, the first legislation to consider health care as a human right was Health Act No 106 of 1973 which seems to have been enacted in response to the accession of Libya to the ICESCR in 1970.

The right to health care was categorised as a human right in article 1 of Act No 106 of 1973. This article states clearly that "all citizens have a recognized right to health care and medical treatment, which the State must guarantee."<sup>484</sup> It seems that this legislation is the

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<sup>484</sup>Health Act 106 of 1973

only legal foundation justifying and identifying the legal status of the right to health care. In spite of the fact that there are several legal documents that are considered as fundamental laws in Libya, such as the Promotion of the Freedom Act No 24 of 1991 and the Great Green Document on Human Rights in the Age of the Masses of 1986, in order to exercise these legal documents in reality the Libyan authorities had to undertake additional legal procedures in other areas of Libyan law but these additional procedures were not undertaken in the health care sector.

With regard to the Great Green Document on Human Rights, for example, the Supreme Court pointed out that the “practicing of the Great Green Document on Human Rights depends on enacting new binding legislation that abolish the present incompatible law, otherwise articles 1 and 3 of the Exercising Principles of the Great Green Document on Human Rights in the Age of the Masses cannot be exercised”.<sup>485</sup> The Libyan Supreme Court also added that “Until the enactment of new legislation or amendment of the existing legislation by the Parliament in the way that make them compatible with the GGDHR provisions, the Court would not be able to apply such provisions before the GPC takes action toward undertaking this change which is matter of Legislature and not of the courts”.<sup>486</sup>

The lack of enforcement and other mechanisms in respect of the right to health care is a serious omission as the current legislation is unable adequately to protect the individual’s right to health care, although it may offer some protection. The importance of the Health Act No 106 of 1973 has been stressed by the Libyan government itself. In its periodic report on the implementation of the International Covenant on Economic, Social and Cultural Rights in 1996, the Health Act was said to be a major and important measure that was taken by the Libyan government to show its commitment to implementing article 12 of the Covenant.<sup>487</sup> However, as has been seen, there is a gap between the theoretical and the practical commitment to the right to health care, resulting in a shortfall between expectation and reality.

This was remarked upon by the International Committee in its comment on the periodic reports submitted by the Libyan government concerning the enforcement of the ICESCR in the country.<sup>488</sup> For example, the International Committee is still not satisfied with the

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<sup>485</sup> Libyan Supreme Court, C 58/38, 23/11/1992, 124

<sup>486</sup> Ibid

<sup>487</sup> Article 2 of the ICESCR also the General Comment No. 14

<sup>488</sup> See Committee on Economic, Social and Cultural Rights, Concluding observations of the Committee on Economic, Social and Cultural Rights, Libyan Arab Jamahiriya, E/C. 12/1/ADD.15, 20 May

Libyan work on human rights in general. In particular, the Committee criticized the Libyan Authorities for not taking all necessary measures to implement the Paris Principles which aim to establish a national human rights institution for protecting and promoting human rights in states parties.<sup>489</sup> Thus Libya has not yet established independent national human rights.<sup>490</sup> With regard to health care, the Committee also observed the failure of the Libyan health authorities to increase the number of doctors per 1000 inhabitants - which was 1.3 per 1000 persons<sup>491</sup> in 2010– after more than two decades, in contrast to Jordan, where for every 10,000 Jordanian citizens there were 24, 5 physicians, 40, 3 nurses 7, 3 dentists and 14, 1 pharmacists.<sup>492</sup> Statistically, this data shows that there was an improvement in the Libyan health services but in reality these numbers do not reflect the situation in terms of the quality of services or whether or not such services are provided by trained and experienced medical professionals.

This failure to implement their obligations is probably the result of a number of factors. The first is that the Ministry of Health in Libya has been unstable over the last two decades and its internal structure, for example, has been altered at least once every two years. The second is the low public expenditure on health care, which has never been higher than 5% of the annual budget, despite the fact that the Libyan government committed itself to spending 15% of its annual budget on health care in accordance with the terms of the Declaration of Abuja 2001.<sup>493</sup> In this context, it is important to note that the strong economy of Libya would suggest that the Libyan government would not face difficulties in providing adequate spending for health care. The third factor is that there is confusion about the nature of human rights in general, and specifically about the concept of the right

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1997, Committee on Economic, Social and Cultural Rights, Concluding observations of the Committee on Economic, Social and Cultural Rights, Libyan Arab Jamahiriya, E/C. 12/LYB/CO/2, 25 January 2006.

<sup>489</sup> General Assembly, resolution No 48/134, National Institutions for Promotion and Protection of Human Rights, 20 December 1993 on line at <http://daccess-dds-ny.un.org/doc/RESOLUTION/GEN/NR0/712/18/IMG/NR071218.pdf?OpenElement> accessed 07/09/2012

<sup>490</sup> Committee on Economic, Social and Cultural Rights, United Nations, Economic and Social Council, E/C. 12/LYB/CO/2, 25 January 2006

<sup>491</sup> Economic and Social Council, Implementation of the international Covenant on Economic, Social and Cultural Rights, Second periodic reports submitted by States parties under articles 16 and 17 of the Covenant, Addendum, Libya (Libyan Arab Jamahiriya), E/1990/Add.38, 15/02/2005 available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G05/404/12/PDF/G0540412.pdf?OpenElement> accessed on 30/09/2012

<sup>492</sup> Health Information Centre, Ministry of Health and Environment, Health and Environment Annual Report 2010, Tripoli, 95

<sup>493</sup> African Union, Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Disease, OAU/SPS/ABUJA/3, 24-27 April 2001, 5 available on line at [http://www.un.org/ga/aids/pdf/abuja\\_declaration.pdf](http://www.un.org/ga/aids/pdf/abuja_declaration.pdf) accessed on 21/07/2011

to health care, despite the fact that Libyan health legislation could be taken to endorse, in theory at least, the right to health care argued for in this thesis. In fact, as has been seen, it has adopted the international definition(s) whose vagueness has already been criticised.

Despite some progress in terms of health care, the health legislation of 1973 is the only legal basis that can be used by individuals and courts to protect the right to health care in Libya. To do so would require the courts, and particularly the Supreme Court, to play an active role in interpreting the legislation. In the next section, the author will explore whether the Supreme Court has done so or not.

### **3.7.2 The Attitude of the Courts to the Right to Health Care**

The similarities between the proposed right to health care in this thesis and the language of the Libyan legislation may increase the expectations of Libyan citizens as to what they can expect in terms of both the delivery and the vindication of this right. It has been argued throughout this thesis that justiciability is a vital element in securing the benefits of the right. Even if there is some academic and political debate as to the status of the right in international law, its specific inclusion in Libyan legislation suggests that it is justiciable in Libya and that courts have an important role to play in developing the right and holding the state to account for any failure to deliver on it.

#### **3.7.2.1 Justiciability of the Right to Health in the Libyan Lower Courts**

In this section, the term ‘lower courts’ is taken to include all courts with the exception of the Supreme Court. At the outset, it must be said that very few cases concerning the right to health care have been brought to the courts. In addition, most of the courts did not treat these cases from the perspective of human rights law even when protection of the right to health care as a human right was raised by the claimant. It is, of course, important to remember that there is no specific human rights law in Libya which may cause confusion as to whether or not a human rights approach is relevant in Libyan courts. Therefore, human rights cases are treated in the same way as other civil cases, whether they concern public or private matters. The protection of human rights is the responsibility of the Civil Code and cases arising from this are examined by the normal court. However, since health care is mostly publicly funded in Libya, and is the responsibility of the Ministry of Health, decisions in this area would normally fall within the jurisdiction of the administrative courts and not the normal courts.

The confusion about the competency of the courts in human rights cases may be the result of the absence of attention to human rights in Libyan political life, compounded by a failure to provide adequate education on human rights, despite Libya's commitments to the recommended educational programme on human rights in accordance with the UN charter.<sup>494</sup> For example, this subject was only taught in law schools as an optional course until 2005 when the Ministry of Higher Education ordered law schools to teach it as part of the mainstream curriculum, in conformity with the United Nations Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms.<sup>495</sup> There are only a few cases concerning human rights brought to courts in Libya, even in respect of civil and political rights, never mind social and economic rights. This fact suggests that more research into the reasons for this could usefully be conducted to inform the new Libya as to how to give human rights their rightful place in terms of priorities.

The lower courts, then, have adopted one of two approaches in such cases. The first is to reject the case on legal grounds. For example, in 2007, a man suffering since birth from swelling in his chest and who had undergone several unsuccessful operations resulting in bleeding went to the Medical Council which decided he required treatment abroad. However, this had to be funded by him and not at the expense of the state. The patient decided to challenge the decision of the Medical Council in the court, asking that the state should pay for all of his treatment expenses. The North Benghazi First Instance Court held that it was not able to consider the case because of its lack of competence in this area. In this case, the judges refused to order the Ministry of Health and the Medical Council of Treatment to permit the claimant to travel abroad for medical treatment. For our purposes, dismissal of this claim is important since it shows that the court did not respect the Supreme Court in this subject area and did not respect the basic rule that gives the decisions of the Supreme Court superiority over other public bodies including the lower courts. In a 2004 judgement, which will be discussed in more detail *infra*, the Supreme Court had stated that treatment was an administrative issue and depended on the will of the relevant health authority, without intervention by other official bodies, including the courts.

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<sup>494</sup>The Charter of the UN, article 1 paragraph 3

<sup>495</sup>The UN, General Assembly Resolution 53/144 (A/RES/53/144), 8 March 1999, available online at <http://www.ishr.ch/hrdo/documents/DeclarationHRD.pdf> accessed on 23/03/2009

According to the Supreme Court, even if the necessary conditions for treatment abroad were met in certain cases, the ultimate decision still falls within the discretionary power of the government, including the Health Authority. In addition, the court pointed out that the failure of the government to provide health care services, in terms of availability, accessibility, acceptability, timeliness and quality was not an adequate reason for prosecuting the administrative authority in court.<sup>496</sup>

Other judges in the lower courts repeated this exact reasoning at another session on 30/05/2007.<sup>497</sup> They also emphasized that there is no legal obligation on the government to send a patient for treatment in another country. This opinion was also adopted by the Basic South Benghazi court (Civil Circuit) in its verdict on 17/02/2008.<sup>498</sup> In regard to the last judgment, the court was led by a judge who had taken a different view in 2006. Judge Mr Abu Reghiha had stated that:

Medical liability occurs whenever the public medical utility offers a bad level of health service or the service takes a long time or is not able to provide certain services at all; in these situations the court pointed out the responsibility of the administration body, including the government, of course, is rising.<sup>499</sup>

In that case, the court concluded that the government should pay 1 million Libyan Dinar to the applicants for the damage that had occurred because of the provision of poor health services. The above judgements show the confusion of the Libyan courts in health matters; the latter court was able to require compensation for providing a bad service while the other refused to give reparation to someone who could not be given appropriate treatment because of the failings of the healthcare system.

The second approach is demonstrated in the Appeal Courts. Although article 31 of the Supreme Court Restriction Act imposes on all other bodies (official and unofficial), including the courts, an obligation to follow any principle that has been laid down by the Supreme Court,<sup>500</sup> the Appeal Courts, particularly in Benghazi, do not always seem to

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<sup>496</sup>See General Comment No 14, 4-5

<sup>497</sup> First Instance court of North Benghazi, Civil Circuit, Case No 366/2007 in 30/05/2007

<sup>498</sup> First Instance court of South Benghazi, Civil Circuit, Case No 1879/2007 in 17/02/2008

<sup>499</sup>The First Instance court of South Benghazi, Civil Circuit, session on Sunday the 9<sup>th</sup> of April 2006, unpublished judgment

<sup>500</sup> Article 31 of the Supreme Court Restriction Act No 6 of 1982

accept this direction. This refusal might be the result of the arguable decisions taken by the Supreme Court, including its judgment in 2003. This will be further considered below.

In 2005 the Benghazi Appeal Court (the Third Civil Circuit) dismissed the judgment of the Supreme Court in 2003 and required the administrative body, specifically the Ministry of Health, to make reparation to a husband whose wife had died as a result of delay in treatment resulting from slow administrative procedures after the Council of Medical Treatment had decided to send her to another country for treatment because of the type of cancer that she had and the inability of the existing health care services in Libya to treat her.<sup>501</sup> In this judgment, the court made a link between the right to health care and the right to life. However, it has been argued in this thesis that this was unnecessary as the right to health care can stand alone. As a member of the ICESCR and by having a commitment in national law to the right to health care, the Libyan government has an obligation to provide health care independently of other human rights.

In another case, the Benghazi Appeal Court (the Fifth Civil Circuit) not only held that the government was civilly liable for the failure of the health care sector to provide health care at the appropriate time, but also went further, declaring that it could also incur criminal liability. The court stated that “more than 30 years after the enactment of the Health Act, we assume that the state should have taken all necessary steps to offer health care services at the right time with high quality and easy access”.<sup>502</sup> Moreover, the court pointed out that if the Medical Treatment Council had stated that the applicant’s daughter should be sent to another country for treatment, this decision should be enough to put her in the legal position to obtain such services without obstruction or undue delay, otherwise the state will be responsible for any unacceptable results that may occur.<sup>503</sup>

In short, it seems that the Court of Appeal in Benghazi had taken a specific direction in contrast to the Supreme Court or other courts in terms of health care and emphasized that the right to health care is a human right in accordance with article 1 of the Health Act No. 106. Therefore, this court had reached the important point of underscoring the status of the right to health care, even if this is in conjunction with the right to life.

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<sup>501</sup>Benghazi Appeal Court (Third Civil Circuit), appeal No.27/2004 and 437/2007, session on 27/12/ 2005

<sup>502</sup> Ibid

<sup>503</sup>Benghazi Appeal Court (Fifth Civil Circuit), appeal No. 170/ 2008, session on 29/06/2008

### 3.7.2.2 The Right to Health Care in the Supreme Court

Because of a lack of a human rights culture in Libya, the Supreme Court has not dealt with many cases concerning human rights, and especially with socioeconomic rights. It is, therefore, difficult to pin down the role of the Libyan Supreme Court in clarifying the legitimacy of human rights. In contrast, in the UK, South Africa, Canada and India the Supreme Courts have played an essential role in describing the legal aspects of the right to health care.<sup>504</sup>

Although the position of the Libyan Supreme Court in regard to economic and social rights is not clear, the Court has paid due attention to civil and political human rights. In respect of the right to have recourse to the courts, for example, the Supreme Court concluded that:

Depriving people of the right of litigation is in breach of all world written and unwritten constitutional instruments, in concept and spirit. However, if any written constitution lacks the concept of people's right to litigation to secure their rights in defence, this right is inherent in Allah's orders and Man's natural rights since creation.<sup>505</sup>

The judiciary is one of the three main authorities in a modern state which builds on the principle of the separation of powers, as explained in constitutional law. The duty of a judicial institution is to solve conflicts between the states' bodies or individuals. In terms of international human rights law as well as constitutional law; seeking justice supposes that there will be independent courts which offer fair and reasonable hearings to any person who is not satisfied with how he has been treated by the authorities. Article 27 of the Constitutional Proclamation 1969 clearly states that "[t]he aim of judicial decisions shall be the protection of the principles of the community and the rights, dignity and freedom of individuals."<sup>506</sup> The function of the courts – and in Libyan terms particularly the Supreme Court - is also emphasized by the International Commission on Economic, Social and Cultural Rights. In its general comment No 14 which is devoted to the right to health care, the International Commission highlighted the fundamental role of the courts as being the protector of the human rights of citizens. In addition, the courts are not only a mechanism

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<sup>504</sup> See Shah, "Illuminating the Possible in the Developing World: Guaranteeing the Human Right to Health in India."

<sup>505</sup> The Libyan High Court, Constitutional Case No. 1/ 14, session 9/4/1395 H, 13 June, 1970.

<sup>506</sup> The Constitutional Proclamation, article 27 available online at <http://unpan1.un.org/intradoc/groups/public/documents/cafrad/unpan004643.pdf> accessed on 24/03/2009

for challenging state violations of human rights, but are also a mechanism to provide a remedy.<sup>507</sup>

However, it would appear that the Libyan Supreme Court has not acted in accordance with the obligations imposed by national and international law, even though these have been accepted by Libyan authorities. Instead of implementing article 1 as primary legislation, which clearly states that the Libyan government is responsible for providing medical care and health care to all citizens, the Court has relied on an executive regulation to conclude that there is no legal obligation on the government to send patients who cannot be treated in Libyan national health institutions to other countries for treatment.

Rejection by the Libyan Supreme Court of the claim that there is a right to seek otherwise unavailable medical treatment abroad is not, however, clearly explained. Indeed, the Court lost a valuable chance to explore the meaning of article 1, preferring instead to accept the government's position that travelling abroad for treatment was not a right but rather was at the discretion of the state.

This misunderstanding of the status of the right to health care by the Libyan Supreme Court seems to derive from two sources. Firstly, the Court has never attempted to identify the nature of the right and whether it is a legal or a political issue. It may be that the Court could benefit from the experience of the courts in the UK, Canada, Sweden, India and South Africa where courts were, for example, able to force the government to declare a maximum waiting times guarantee.<sup>508</sup> Secondly, the Libyan Supreme Court has not focused on any conceptual analysis of the right to health care. It has not attempted to define what the right means, nor when it should be provided and to whom, especially in emergency cases. Additionally the Court has never tried to construct a clear concept of the place of socioeconomic rights in general.

In respect to the judgments of the Supreme Court, several observations can be made. The Court has not recognised any sort of correlation between the right to health care and the right to life, whereas other courts such as the Indian Supreme Court and South African Constitutional Court have focused on this relationship between the two to conclude that the importance of right to health care arises not only from its legal status in both national and international law but also from its importance for the enjoyment of a fundamental civil

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<sup>507</sup> General Comment No 14

<sup>508</sup> For example the efforts of the UK concerning this scheme can be seen in these references, R. Lewis and J. Appleby, "Can the English Nhs Meet the 18-Week Waiting List Target?," *Journal of the Royal Society of Medicine* 99, no. 1 (2006)., AN INDEPENDENT AUDIT OF THE NHS UNDER LABOUR (1997–2005), King's Fund 2005, 21-30

right such as the right to life.<sup>509</sup> This correlation has played a fundamental role in emphasising the importance of the right to health care even in countries that have not signed or ratified the ICESCR.<sup>510</sup>

The second observation is that, while most constitutional legal systems acknowledge that the responsibility of the government is collective and not individual, the Supreme Court has taken a different view. In its reasoning, the Supreme Court (third civil circuit) declined to determine the responsibility of health authorities for the death of a patient who was put on the waiting list to travel to another country for treatment, because financial issues are handled by the Ministry of Finance and not the Ministry of Health.<sup>511</sup> This division of responsibility between the Ministries resulted in the denial of a right to health care and ultimately to the denial of the right to life, despite the fact that the Court had the authority to dispense justice for the victim and his family. Most importantly it had the authority, although it did not use it, to recommend the government to institute an appropriate health care system that would allow the citizens of Libya to attain good health care services or at least to travel abroad for treatment at an appropriate time.<sup>512</sup>

Because the Supreme Court is a 'Court of law' and not a 'Court of fact' it should take human rights more seriously than the lower courts. Indeed, its main function is to review the judgments of the lower courts and to ensure that the law is applied and interpreted in the same way throughout the entire state. As a result of the ratification of international human rights agreements, the Libyan courts, particularly the Supreme Court, are required to treat human rights seriously otherwise they may face intervention from international organisations, such as the International Commission on the Economic, Social and Cultural Rights or the African Court of Justice and Human Rights (once it has started its operation). According to many international legal instruments, such as General Comments No 3 and 14 as well as the Vienna Declaration and Programme of Action in 1993, there is an obligation on the state party to protect the Economic, Social and Cultural rights of citizens

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<sup>509</sup>O. Nnamuchi, "Kleptocracy and Its Many Faces: The Challenges of Justiciability of the Right to Health Care in Nigeria," *Journal of African Law* 52, no. 01 (2008). 10. See also the references cited in previous chapters that emphasize this notion.

<sup>510</sup> Good examples of these countries are Republic of South Africa, Cuba and the United States of America. These countries, especially South Africa, have legally provided health care as a legal right to their citizens. Recently, United States of America started to follow other developed countries in this direction. One can find out the countries that have not ratified the ICESCR by following this link [http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg\\_no=IV-3&chapter=4&lang=en](http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en) accessed on 26/04/2012

<sup>511</sup> Libyan Supreme Court (third civil circuit), Case No 128/53, 26/02/2008

<sup>512</sup> In many cases brought to it, the Libyan courts have dismissed the cases because, in general, judges still believe that health care issues are a matter for governmental discretion that cannot be adjudicated by courts.

by creating and implementing all necessary policy, legislative, judicial and enforcement frameworks. In this context, it is important to point out that the judiciary is not only a legal mechanism for judging the actions of governments in regard to human rights but it is also responsible for ensuring that the state authorities, including the judiciary itself, take all necessary steps to realise human rights. Otherwise they may face censure from the international community.<sup>513</sup>

In Libya, it is likely that there are several problems concerning the implementation of human rights in reality. As has been said, the first problem is that neither individuals nor the authorities - including the courts - use the explicit language of human rights. By looking at some of the courts' decisions more closely, one can see confusion about the legitimacy of the right to health care, despite the fact that the right (however defined) is specifically contained in the Health Act. Furthermore, because cases concerning human rights were handled by judges who were not educated in the human rights field, it seems that they were not sure where socioeconomic rights such as right to health care should be listed. In fact, they adopted the traditional view which believes that health care falls largely into the political field rather than the legal sphere.<sup>514</sup>

If the right to health care is treated as a political right, its exercise will be controlled merely by the government and the courts will be unable to intervene. Thus, Libyan courts have been reluctant to review health strategies from a human rights viewpoint as Forman has explained.<sup>515</sup> In the latter part of the 1980s and the earlier part of the 1990s, this perspective was abandoned by courts all over the world, for instance, the South African Constitutional Court, which has benefited from using the language of human rights enshrined in the new Constitution, particularly in section 27.<sup>516</sup> This section was clear enough for the Constitutional Court of South Africa to rely on to declare that social rights, such as the right to health care, are justiciable rather than merely aspirational. Moreover, the South

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<sup>513</sup>M. Ssenyonjo and MyiLibrary, *Economic, Social and Cultural Rights in International Law* (Hart Pub., 2009). 24

<sup>514</sup>Forman, "Ensuring Reasonable Health: Health Rights, the Judiciary, and South African Hiv/Aids Policy." 711, C. Ngwenya, "The Recognition of Access to Health Care as a Human Right in South Africa: Is It Enough?," *Health and Human Rights* (2000). See also, Annas, "The Right to Health and the Nevirapine Case in South Africa."

<sup>515</sup>Forman, "Ensuring Reasonable Health: Health Rights, the Judiciary, and South African Hiv/Aids Policy." 711

<sup>516</sup>The section is formulated as follows: 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 realization of each of these rights. 3) No one may be refused emergency medical treatment. Constitution of the Republic of South Africa Act No 108 of 1996, available at <http://www.info.gov.za/documents/constitution/1996/a108-96.pdf> accessed on 26/04/2012

African Court has been prepared to explore the quality of health care delivered by the state and the funding made available to it.<sup>517</sup>

It also seems that citizens in Libya have not realized the real meaning of the right to health care and the jurisprudence on this issue has been confined largely to two areas; first, the right to travel overseas for treatment and second the attempt to obtain compensation for harm resulting from the slow delivery of services. The Committee on Economic, Social and Cultural Rights has observed that the Libyan authorities have failed to take serious measures to implement ICESCR; in particular, they have not yet adopted legislation to protect citizens against discrimination.<sup>518</sup>

It can be concluded, therefore, that the culture of human rights is not yet embedded in Libya, despite the fact that the Libyan Government has ratified and acceded to the majority of human rights agreements since independence. It has not responded positively to the obligations resulting from these international agreements. For instance, domestic laws need to be amended in order to be compatible with these obligations. According to the UN Charter and other declarations, and UN principles such as the United Nations Basic Principles on the Independence of the Judiciary, the Basic Principles on the Role of Lawyers and the Paris Principles, states parties are obligated to spread the concept of human rights to their citizens. Furthermore, states parties should develop and support independent institutions. The International Committee has demanded that the Libyan authorities provide training programmes on human rights and on the Covenant, particularly for judges and others who are responsible for fulfilling the obligations of the Covenant.<sup>519</sup> This lack of implementation concerning human rights can also be related to the absence of a political will that intends to respect human rights and create a culture of rights throughout society in general.

In short, it should be understood that the aim of a human rights culture should be to enhance human rights themselves by instituting certain institutional mechanisms and by being politically willing to act in accordance with the values of human rights.<sup>520</sup> Thus, if the Libyan authorities really believe in human rights, and for our purposes particularly the right to health care which is also rooted in domestic law, they must encourage the

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<sup>517</sup>B.M. Meier and A.E. Yamin, "Right to Health Litigation and Hiv/Aids Policy," *The Journal of Law, Medicine & Ethics* 39(2011). 82

<sup>518</sup> The UN, Economic and Social Council, International Committee on Economic, Social and Cultural Rights, 25 January 2006, E/C.12/LYB/CO/2, <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G06/402/15/PDF/G0640215.pdf?OpenElement> accessed on 26/04/2012

<sup>519</sup> Ibid

<sup>520</sup> Ibid, 8

independence of the judiciary and allow citizens to vindicate their rights before them. As a result, Libyan authorities could achieve two goals. Firstly, a human rights culture would be encouraged in the country, taking account of its own characteristics and taking into account the nature of its economic and social structure. Secondly, establishing a national human rights culture would help the state to avoid the embarrassment of being judged adversely by international bodies.

The second dilemma is that the courts have difficulty in accessing the legal information and data which judges usually use to develop their reasoning. In regard to the cases concerning travelling abroad for medical treatment, the judges have mainly relied on decree No 975 of 1980 to make their decisions, but this decree was abolished by several later decrees such as the General People's Committee decree no 6 of 1994 on health and social security<sup>521</sup>. In order to avoid this situation, sources of information or a data network needs to be built between the judicial, executive and legislative bodies to enable the exchange of relevant information.

As mentioned above, the third problem facing human rights in Libya is the absence of a comprehensive and precise set of human rights. The status of the right to health care in the Libyan legal system depends merely on one article in the health legislation and this, in fact, causes problems rather than provides solutions to the question whether this right is legally protected or not, and if so to what extent. Therefore, a clear set of human rights including the right to health care is required in order to clarify all of these complicated matters on the position of health care in Libya. If these were clarified, Libyans would not only be the bearers of enforceable rights against the state but they could also have the right to participate in how these rights can be implemented in reality.<sup>522</sup> Moreover, it is worthwhile noting that there is general agreement about the supremacy of the judiciary's role in the human rights field. As Hunt, for example, has pointed out, protection of human rights has given the judiciary supremacy over the legislature and the executive in the interpretation of fundamental rights.<sup>523</sup>

The fact that the right to health care appears in domestic legislation in Libya does not apparently entail that it is binding or legally prioritised. Enactment of a dedicated human rights Act in Libya would clarify both the legal status of human rights and the

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<sup>521</sup> Official Gazette, Decree of the General People's Committee for Health and Social Security (Now Environment) No 6/1994 on medical treatment abroad, No 15, 457

<sup>522</sup> M. Hunt, "The Human Rights Act and Legal Culture: The Judiciary and the Legal Profession," *Journal of Law and Society* 26, no. 1 (1999), 89-90

<sup>523</sup> *Ibid*, 90

responsibility of the state to implement them. It would also clarify which body has the authority to hear allegations of violation. At state level, adopting legislation for human rights would also demonstrate the state's commitment to fulfilling its international obligations. As explained above, most human rights agreements, regardless of their regional or universal effect, require states parties to undertake all necessary measures to ensure the implementation of these rights.<sup>524</sup> Ultimately, the problem has resulted from the nature of human rights as part of international law.<sup>525</sup>

Much has been written in the past about the nature of international law. In general, there are two opposing views. The first is that international law, which includes human rights' law to some extent, is not 'true law'. On this view, law is not law if it does not have the necessary machinery to enforce it.<sup>526</sup> In contrast with national law, in the international sphere there are no superior powers such as courts, police or legislature which can ensure that international rules are respected by the members of the international community.<sup>527</sup>

According to the second view, law is not only law if it can be enforced, but rather because it is commonly agreed to be law by the society to whom it is addressed.<sup>528</sup> In addition, it is argued that the comparison between national and international law is invidious, since they are different entities in respect of, for example, legal subjects, and scope and enforcement mechanisms.<sup>529</sup> In comparison to international law, national law is different in that the state is located at the top and is empowered to make orders and ensure that the law is applied in a proper way, by both natural persons and legal persons. The authorities of the state, such as the executive, the legislature and judicial bodies are authorized to issue, enforce and apply the law. These authorities are accepted by the community as a civilized way to solve the disputes that may occur between its members.

This should not mean that international law is not legally enforceable, but it is important to understand that the enforcement of international law depends on the willingness of member states to do so. There are several enforcement mechanisms, such as the UN Security Council, loss of legal rights and judicial enforcement; however, such methods cannot be used effectively unless the international community members come to an agreement to do

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<sup>524</sup> See article 2 of the ICESCR and the general comments No 3&14.

<sup>525</sup> Javaid. Rehman, *International Human Rights Law: A Practical Approach* (London: Pearson Education, 2003). 13-15

<sup>526</sup> Dixon, *Textbook on International Law*.13-15

<sup>527</sup> A. Cassese, "International Law, 2 E Éd," (Oxford, Oxford University press, 2005). 3-13

<sup>528</sup> Dixon, *Textbook on International Law.*, 6, Cassese, "International Law, 2 E Éd."135-36, Malcolm D.Evans., *International Law* (Oxford2006). 281-82

<sup>529</sup> Cassese, "International Law, 2 E Éd." 3-13

so. In terms of human rights, it should also be clear that human rights can be derived from domestic legal systems as well as from international law, but that the enforcement of human rights will depend on the constitution, if there is one, and the relationship between national and international law.

A state usually enforces international law by using one of the two following techniques. The first legal tool is that of transformation.<sup>530</sup> Under the doctrine of transformation, international law cannot be a part of national law until it has been intentionally transformed into domestic law in an appropriate manner. Only in this case will national courts apply international rules internally. The second legal tool is incorporation.<sup>531</sup> Incorporation means that the rules of international law automatically become a part of national law, so that there is no need for any other additional action for them to be considered as part of national law; domestic courts can apply them directly.

In Libya, it seems that implementation of international law by national courts depends on the type of international rule that is to be applied domestically and whether it is a customary rule or a conventional rule. In regard to customary international law, Libyan courts often apply this directly but this is not the situation with the rules of international law that derives from international conventions. In this case, it seems that Libyan courts follow the doctrine of transformation which prevents national courts from applying the international rule until it is directly transformed into national law.<sup>532</sup>

The alleged weakness of international law, such as its lack of institutions, lack of certainty, vital rules and vital interests, must not blind one to the fact that international law has instituted several mechanisms for implementing rights, including obliging individual states to undertake certain duties, such as submitting an annual report about the situation of human rights in its territory, taking human rights seriously when it prepares its policies and allowing citizens to use the national judiciary to gain such rights. In addition, most human rights conventions have established international bodies to monitor the implementation of the convention by the states parties.

Therefore, international law has developed several mechanisms that can be used to require the state to respect, protect and fulfil its human rights obligations. In regard to

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<sup>530</sup>D.Evans., *International Law*. 428, Cassese, "International Law, 2 E Éd." 220, Robert. MacLean, *Public International Law Textbook*, 17th ed. (1995). 30, M. N. Shaw, "International Law, 5th," (Cambridge University Press, 2003). 129

<sup>531</sup>Shaw, "International Law, 5th." 129, Cassese, "International Law, 2 E Éd." 221, MacLean, *Public International Law Textbook*. 30

<sup>532</sup>A.M. Slaughter and W. Burke-White, "Future of International Law Is Domestic (or, the European Way of Law), The," *Harv. Int'l LJ* 47(2006).

socioeconomic rights, particularly the right to health care, Libyan citizens seem to have a good opportunity to force the Libyan government to provide such a right. Additionally, as will be seen, as a result of Libya's membership of the African Union, it should be possible to approach the African Court of Justice which can agree to examine citizens' claims directly. Likewise, if the Libyan government were to sign the Optional Protocol on Economic, Social and Cultural Rights, Libyan citizens also would have the opportunity to use the International Committee on Economic, Social and Cultural Rights to claim their rights, as will be discussed further below.

As a result, arguably, international law has sufficient mechanisms to enforce its rules and fill the gap if national institutions, including courts, are not able or willing to do so.

### **3.8 The International Health Care Commitments of the Libyan Government**

As a member of the African Union and the United Nations, the Libyan government is obligated by any agreement that is adopted by these international organizations. Thus, in relation to subjects such as health care, Libya may find itself bound by two types of international obligations: African and international. However, as a general principle, if Libya is a state party to an international agreement and has taken all necessary legal steps such as signing and ratifying it, international responsibility will follow, regardless of whether the agreement was adopted by the African Union or other international organisations. Thus, to avoid international opprobrium the state must do its best to implement its international commitments.

#### **3.8.1 The Health Care Commitments of the African Union**

Libya is a member of the African Union (AU). Membership of the Union gives rise to obligations. In terms of health affairs, the AU has always paid great attention to the improvement of its population's health, and considers that improvement of the health status in the region is a key element in the development of this area of the world.<sup>533</sup> In respect of Libya's health care obligations under the African human rights' system, three fundamental issues will be discussed. Firstly, the legal foundation of these obligations and how much these commitments fit with the proposed definition of the right to health care as outlined in this thesis will be considered. Secondly, the legal value of these commitments

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<sup>533</sup> To view these linkages see D. Tarantola et al., "Human Rights, Health and Development," *University of New South Wales Faculty of Law Research Series* (2008).

will be explored, and finally the mechanism that could be used to enforce the obligations of the states parties will be identified.

### **3.8.2 The Legal Sources of the African Union (AU) Health Care Commitment**

The importance of health care in Africa can be seen from the number of agreements and declarations that have been ratified by most African countries. Health related matters are specifically included in the Constitutive Act of the AU where health care is listed as one of the objectives of the African Union. According to article 3, members of the African Union are required to improve the situation of human rights in the African continent, especially with regard to the right to health care.<sup>534</sup>

Moreover, the right to health care has been referred to in a number of African agreements such as the African Youth Charter 2006,<sup>535</sup> the African Charter on the Rights and Welfare of the Child 1990,<sup>536</sup> and the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa.<sup>537</sup> While these charters recognized the right to health care as a human right with specific reference to age or gender, this does not mean that the right to health care in Africa only applies to these groups. Indeed, the right is contained in the African Charter on Human and People's Rights which is seen as a general human rights document for all African people. In the words of the Charter itself:

Every individual shall be entitled to the enjoyment of the rights and freedoms recognized and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, color, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or other status.<sup>538</sup>

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<sup>534</sup> African Union, Constitutive Act of the African Union, 2000, available online at [http://www.africa-union.org/root/au/AboutAU/Constitutive\\_Act\\_en.htm](http://www.africa-union.org/root/au/AboutAU/Constitutive_Act_en.htm) 23/08/2012

<sup>535</sup> African Union, African Youth Charter adopted by the seventh ordinary session of the Assembly, held in Banjul, the Gambia on 02/07/2006, access on 16/08/2009 available on line at [http://www.africa-union.org/root/au/Documents/Treaties/Text/African\\_Youth\\_Charter.pdf](http://www.africa-union.org/root/au/Documents/Treaties/Text/African_Youth_Charter.pdf)

<sup>536</sup> See article 14 of the Charter of 1990, available on line at <http://www.africa-union.org/root/au/Documents/Treaties/Text/A.%20C.%20ON%20THE%20RIGHT%20AND%20WELF%20OF%20CHILD.pdf> accessed 16/08/2009

<sup>537</sup> See article 14 of the African Charter on women of 2003, available online at <http://www.africa-union.org/root/au/Documents/Treaties/Text/Protocol%20on%20the%20Rights%20of%20Women.pdf> accessed 16/08/2009

<sup>538</sup> The AU, African Charter on Human and People's Rights, *Adopted 27 June 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982, entered into force 21 October 1986*, available online at <http://www.africa-union.org/root/au/Documents/Treaties/Text/Banjul%20Charter.pdf> accessed on 16/08/2009,

In relation to the right to health care, article 16 of the African Charter on Human and People's rights states that "1. Every individual shall have the right to enjoy the best attainable state of physical and mental health. 2. States parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick."<sup>539</sup> Therefore, Libya, as with other member states of the African Union, is required to do its best to ensure the enjoyment of the rights and freedoms recognized by the Charter, particularly the right to health care, after signature and ratification of the Charter by the Libyan authorities. These rights and freedoms then became a part of domestic law and all state authorities, including the legislature and the judiciary, must undertake all necessary steps to ensure that these rights are enjoyed by all citizens.

In regard to the responsibilities of the state, it is essential to note two points. First, Libya is a member of different regional and international organizations. For instance, besides the AU, Libya is a member of the Arab League, the WHO and the WHO Regional Office for the Eastern Mediterranean, all of which deal with health care issues and have their own agenda about health care and how it should be delivered. Secondly, these memberships are likely to have an effect on the understanding of the right to health care and its scope by the Libyan authorities, as well as on the expectations of its citizens. Understanding the concept of the right to health care widely or narrowly is likely to make a difference in the manner of its implementation and the associated costs, which are the main problems that face all states when they work to achieve the right.

### **3.8.2.1 The Right to Health Care in the African Charter**

As has been shown above, the most valuable human rights document in Africa is the African Charter on Human and People's Rights because it specifically relates to human right issues in Africa and, in addition, it has instituted monitoring bodies to observe the implementation of these rights in reality. For this reason, the examination of the right to health care from an African perspective will rely mainly on article 16 of the Charter which deals with the right to health care, but this does not mean that other articles that concern health care in other African agreements will not be referred to where appropriate.

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<sup>539</sup> Ibid. 5

In article 16 of the African Charter, The first paragraph of the article is likely to be influenced by the international articulation of the right to health care where it uses vague terms such as ‘the best attainable state of physical and mental health’ which is difficult for governments and individuals to interpret. Indeed, this language seems to imply the right to be healthy, which has been widely criticized as unattainable, rather than the right to health care, which is proposed in this thesis. On the other hand, some advantages may flow from this article in terms of both its articulation and target. Given the wording of the article, it seems to be clear that there is a compulsory obligation on the state party to provide health care services to its citizens. The phrase ‘Every individual shall have’ is likely to be more certain than the wording of article 12 of the ICESCR which only requires states parties to undertake all necessary steps to achieve the full realization of this right.

Under paragraph 2 of this article, the state party is required to act positively to protect its people from being sick and to ensure that they can receive medical care when they are sick. This aspect of the article seems closer to the meaning of the right to health care espoused in this thesis; one that is workable, reasonable and justiciable. Although the legal status of the right to health care as a human right under the African Charter is apparent, other African human rights documents that include articles about the right to health care, such as the African Youth Charter 2006, the African Charter on the Rights and Welfare of the Child 1990 and the Protocol to the African Charter on Human and People’s Rights on the Right of Women in Africa, are also useful to determine the extent and scope of the right to health care.

Article 14 of the African Charter on the Rights and Welfare of the Child 1990 listed several measures that the states parties of the Charter shall undertake to ensure the full implementation of the right to health care.<sup>540</sup> However, the African Charter in general used a

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<sup>540</sup>Article 14 of the African Child Charter states that “1. Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health. 2. States Parties to the present Charter shall undertake to pursue the full implementation of this right and in particular shall take measures: (a) to reduce infant and child mortality rate; (b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; (c) to ensure the provision of adequate nutrition and safe drinking water; (d) to combat disease and malnutrition within the framework of primary health care through the application of appropriate technology; (e) to ensure appropriate health care for expectant and nursing mothers; (f) to develop preventive health care and family life education and provision of service; (g) to integrate basic health service programmes in national development plans; (h) to ensure that all sectors of the society, in particular, parents, children,

community leaders and community workers are informed and supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of domestic and other accidents; (i) to ensure the meaningful participation of non-governmental organizations, local communities and the beneficiary population in the planning and

similar list of contents to those usually included in national health legislation; thus the focus was placed on preventive or curative programmes, and its first paragraph uses the terminology common to other international human rights documents which has been argued in the first chapter of this thesis to be vague and uncertain.

In terms of the obligations under the African Charter on Human and People's Rights, it can be argued that Libya has accepted a clear international commitment to provide health care services for its citizens. In addition, it seems that Libya should be able to meet all required financial expenditure to provide high quality services, given its economic situation. In any case, the Libyan government is required at least to fulfil its commitment,<sup>541</sup> as with other African governments, to spend 15% of its annual budget on health care services. This was agreed by all African governments at the Abuja Summit in 2001. In Abuja, the African leaders recognized the extent to which the development of Africa had been affected by health related problems. For instance, in its health report in 2006, the WHO Regional Office for Africa clearly stated that economic growth and social progress in Africa cannot be achieved under the current health status; thus there is a need to increase investment in health in the Continent.<sup>542</sup> For example, HIV/AIDS, tuberculosis and malaria are big challenges. They remain the major threats to public health in the Continent.<sup>543</sup> According to the World Malaria Report in 2008, the WHO pointed out that 91% of the malaria deaths in 2006 were in Africa and 85% were of children under 5 years of age.<sup>544</sup> In addition, it has been reported that sub-Saharan Africa has 68% of worldwide HIV infections and more than 76% of AIDS-related deaths.<sup>545</sup>

Given evidence such as this, African leaders recognized the problems and agreed to meet in Abuja in 2001. At this summit, they agreed that solving health related problems in Africa required that African countries and their partners such as the UN, the USA, the EU

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management of a basic service programme for children; (j) to support through technical and financial means, the mobilization of local community resources in the development of primary health care for children.

<sup>541</sup>Obiajulu Nnamuchi., "Kleptocracy and Its Many Faces: The Challenges of Justiciability of the Right to Health Care in Nigeria.," *Journal of African Law* 52, no. 1 (2007). 9-11

<sup>542</sup>The WHO regional office for health in Africa, 2006, the African regional health report, p xxiii available online at: [http://www.afro.who.int/regionaldirector/african\\_regional\\_health\\_report2006.pdf](http://www.afro.who.int/regionaldirector/african_regional_health_report2006.pdf) accessed 11/03/2009

<sup>543</sup>WHO regional office for Africa, 2008, the work of WHO in the African region 2006-2007 to the fifty-eighth session of the Regional Committee for Africa, Yaounde, Cameroon, 1-5 September 2008, p 13 available at <http://www.afro.who.int/rc58/documents/en/AFR-RC58-2%20Biennial%20Report%202006-2007.pdf> accessed 11/03/2009

<sup>544</sup>The WHO, world malaria report 2008, p viii, available at <http://www.who.int/malaria/mediacentre/wmr2008/malaria2008.pdf> 11/12/2008

<sup>545</sup>WHO regional office for Africa, 2008, 13

and the WHO undertake a number of commitments. At that summit, African leaders took an extremely important decision for the economic growth and social progress of their countries by committing themselves to devoting 15% of the state's annual national budget to the development of the health sector.<sup>546</sup> Unfortunately, many African countries have not met this laudable aspiration and their failure to meet this target has been widely criticized.<sup>547</sup>

In terms of Libya, it appears that there may be two reasons for this failure. Firstly, Libya still seems to regard the right to health care as a political rather than a legal right. For this reason, one can conclude that there is no political will to deal with health care as a legal right that the government is obliged to provide to its citizens and that citizens can challenge in the courts if they are not satisfied with these health services. In other words, it seems that the Libyan authorities still believe that health affairs lie within the jurisdiction of the executive, without judicial intervention. Secondly, historically Libya has never spent more than 4% of its annual budget on health care services. In terms of its Abuja commitments, Libya is still lagging well behind. It is also important that, if states are to fulfil their obligations in terms of the right to health care, there must be mechanisms in place that can enforce the obligations accepted by states.

### **3.8.2.2 The Legal Value of the African Human Rights Document**

In principle, the implementation of any international treaty requires two sorts of procedures that have to be taken by the state party to ensure that the treaty enters into force in that state. The first of these concerns the internal procedures that translate international agreements into domestic law - in the case of Libya this is the responsibility of the General People's Congress. In international law, this is called 'ratification'. The same procedure is required at international level so that other states parties can be aware that Libya has ratified the treaty and intends to implement it.<sup>548</sup> The second procedure is that completion

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<sup>546</sup>Abuja Declaration on HIV/AIDS, Tuberculosis and other related Infectious Diseases, 2001, OAU/SPS/ABUJA/3, 5, available online at [http://www.un.org/ga/aids/pdf/abuja\\_declaration.pdf](http://www.un.org/ga/aids/pdf/abuja_declaration.pdf) accessed on 11/03/2009

<sup>547</sup>V. Govender, D. McIntyre, and R. Loewenson, "Progress Towards the Abuja Target for Government Spending on Health Care in East and Southern Africa," *Health Economics Unit, University of Cape Town, Cape Town and EQUINET, Harare* (2008). (Actionaid International Africa, Four Years after Abuja: more action required on spending commitments!, Nairobi, 2005, K. Bachenberg et al., "Show Me the Money: Achieving Economic, Social, and Cultural Rights through Government Budgets," (2011)., 91

<sup>548</sup>Brownlie, *Principles of Public International Law*. 582-83

of the ratification means that, in the international sense, the treaty has entered into force, at least between those states which have completed this procedure.

In regard to Libya's African human rights obligations, including health care, review of the signature and ratification list of these agreements can prove that Libya has signed and ratified all the African human rights agreements, which means that these agreements are binding on the Libyan government.<sup>549</sup> Therefore, Libyan authorities should take all necessary steps to fulfil these obligations and act in a manner compatible with these commitments otherwise Libyan citizens can seek their rights through international institutions.

In addition, the African Charter on Human and People's Rights, for example, is not the only international instrument that outlines international responsibilities for the state and provides authority for a monitoring body to issue judgment against the Libyan government. Such judgements would embarrass Libyan authorities, particularly the courts, and place pressure on them to take human rights seriously.

In short, it has been shown that there are legal obligations that result from the African Union human rights system and Libya, as part of this Union, has committed itself to implementing them. While, theoretically, Libya appears to have done this, there is still much that needs to be done to ensure that the right to health care is taken seriously in practice. The failure of the Libyan authorities to vindicate socioeconomic rights, and particularly the right to health care, may derive from its uncertainty about the concept of human rights in general. Libyan authorities, especially the judiciary, need to upgrade their understanding of human rights and in particular to regard them as matters of law rather than as political issues.

Understanding human rights correctly will assist in moving them from rhetoric to reality, and will ensure that all sectors of the state accept the responsibility for implementing and supporting them. Moreover, reconciliation of the legal status of human rights with the ability of the government to lead the state will avoid international criticism and possible intervention.

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<sup>549</sup>African Union, Treaties, Conventions, Protocols & Charters, available on line at [http://au.int/en/sites/default/files/African%20Charter%20on%20Human%20and%20Peoples'%20Rights\\_0.pdf](http://au.int/en/sites/default/files/African%20Charter%20on%20Human%20and%20Peoples'%20Rights_0.pdf) accessed 22/09/2012

### 3.8.2.3 Human Rights Protection in the African Union and Libya

It has already been noted that the African human rights system created monitoring mechanisms to evaluate the adherence to human rights by member states. There are, in fact, two such mechanisms; the African Commission on Human and People's Rights (the African Commission) which is instituted in accordance with article 30 of the African Charter, and the African Court on Human and People's Rights which was established in 1998 to complement and reinforce the function of the African Commission.

Of course, the African institutions that will be examined in this section are not the only mechanisms responsible for monitoring the human rights situation on the continent. In fact, the protection and promotion of human rights in Africa is also the responsibility of a number of institutions and organs such as the Assembly of the AU, the Executive Council, the Pan-African Parliament and other organizations.<sup>550</sup> However, the focus here on the African Commission and the African Court is important since these bodies have direct responsibility in the region.

Although the AU has laid the framework for achieving the development of respect for human rights in the region, it seems that it has been less successful in achieving this than other systems, such as those that exist in Europe and the United States. This lack of progress can be attributed to the slow progress of the implementation of human rights by the states parties, suggesting that there is little political will to take action in this area. For example, the African Court was established in 1998 and has been able to hear cases since 2004, yet it has never examined any human rights cases because of disagreement between the states parties over the selection of judges and financial support. These problems increased when the states parties agreed to combine the jurisdiction of the African Court of Justice and the African Court on Human and People's Rights under the African Court of Justice and Human Rights. The treaty to implement this change was opened for signature and ratification in 2008. However the African people will need to wait for ratification before the court is able to commence its business.

Meantime, the next section of the thesis will provide a brief discussion of the role of the two mechanisms described above with particular focus on their role in ensuring respect for human rights in the region. More importantly, it will show how Libyan citizens can utilize them to vindicate the right to health care if internal mechanisms are unable to protect this right.

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<sup>550</sup>G. M. Wachira, *African Court on Human and Peoples' Rights: Ten Years on and Still No Justice* (Minority Rights Group International, 2008). 6

### 3.8.2.3.1 The African Commission on Human and People's Rights

The African Commission was established in accordance with article 30 of the African Charter on Human and People's Rights. It aims to promote and protect human rights in Africa. Both the African Charter and the African Commission have been seen as significant improvements in terms of the recognition and implementation of human rights in the continent.<sup>551</sup>

The Commission started operations in 1987 and consisted of eleven members.<sup>552</sup> Members of the Commission must be legally qualified and should have practical experience of judicial or human rights work. The members of the Commission must also show personal integrity. In addition to the functions referred to above, the Commission has extended its jurisdiction to allow the interpretation of the provisions of the African Charter and the examination of the reports on human rights which each state party must submit every two years; however this function was not exclusively designed for the Commission under article 62 of the Charter.<sup>553</sup>

The Commission's importance is that individuals and non-governmental organizations are permitted to bring cases to the court, as are states parties and intergovernmental organizations. The claimant has to exhaust all national legal remedies including the courts before he or she is able to bring the case in question to the Commission.<sup>554</sup> This requirement in the Charter has, however, been argued to be unrealistic in African countries where local institutions such as the police and the judiciary usually are controlled by the head of the state or the government.<sup>555</sup> In order to fulfil its function, the Commission holds two ordinary sessions every year in Banjul, The Gambia where it is based, or in any other African capital city. In reaching its decisions, in accordance with article 60 it can rely on any appropriate source of international law such as international conventions, international

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<sup>551</sup> See D. Juma, "Access to the African Court on Human and Peoples' Rights: A Case of the Poacher Turned Gamekeeper?," *Essex Human Right Review* 4, no. 2 (2007). 2

<sup>552</sup> Art 31, para 1

<sup>553</sup> Article 62 of the African Charter states that "Each state party shall undertake to submit every two years, from the date the present Charter comes into force, a report on the legislative or other measures taken with a view to giving effect to the rights and freedoms recognized and guaranteed by the present Charter." See K. Quashigah, "African Charter on Human and People's Rights: Towards a More Effective Reporting Mechanism, The," *Afr. Hum. Rts. LJ* 2(2002). 263

<sup>554</sup> C.A. Odinkalu, "Africa's Regional Human Rights System: Recent Developments and Jurisprudence," *Hum. Rts. L. Rev.* 2(2002)., 106-107

<sup>555</sup> Michelo Hansungule, "Towards a More Effective African System of Human Rights: "Entebbe Proposals", "[http://www.biicl.org/files/2309\\_hansungule\\_towards\\_more\\_effective.pdf](http://www.biicl.org/files/2309_hansungule_towards_more_effective.pdf). accessed on 28/05/2009

customary law and any other international instruments of which the parties to the Charter are members.

Another function of the Commission is its interpretive duty in relation to human rights in Africa. On occasion the Commission has successfully used this role to expand its jurisprudential base and its interpretative work has been described as mostly positive and occasionally innovative.<sup>556</sup>The Commission also has to publish research and undertake studies into human rights in Africa. This function, however, is difficult to achieve given its lack of financial resources, although this problem could be minimized were the Commission to work closely with other relevant institutions such as UN human rights bodies or NGOs which may be able to assist in this matter.<sup>557</sup>

According to article 2 of the Court Protocol, the role of the Court is to enhance and complement the role of the Commission; not to replace it. Both bodies, therefore, need to find a way to implement this notion of complementarity that is required by the Protocol. Complementarity here should mean that neither of these bodies can negatively affect the other's work. For example, the Commission should not take too much time when considering a case before transferring it to the Court.<sup>558</sup> Hopkins stated that "the African Court cannot function in on its own. It will make little or no meaningful difference to the promotion and protection of human rights on the continent unless it works closely with, and complements the work of the African Commission."<sup>559</sup>

Complementarity between these bodies means that the Commission can use the judgments of the African Court, when it operates, as sources of international law or law case, and the Court may use the investigation and information that the Commission has about a particular case to assist it in reaching a final decision. In addition, this shows also that the Commission has to realize that the judgments of the Court, as will be highlighted below, are final and compulsory for all states' parties. Thus, the rules of procedure should include a rule providing that, in the case of a serious violation of human rights, the Commission must transfer the case to the Court immediately.

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<sup>556</sup> See C.A. Odinkalu, "Individual Complaints Procedures of the African Commission on Human and Peoples' Rights: A Preliminary Assessment, The," *Transnat'l L. & Contemp. Probs.* 8(1998). 402

<sup>557</sup> Wachira, *African Court on Human and Peoples' Rights: Ten Years on and Still No Justice.* 11

<sup>558</sup> I.A.B. Elsheikh, "Future Relationship between the African Court and the African Commission," *Afr. Hum. Rts. LJ* 2(2002). 255; see also R. Murray, "Comparison between the African and European Courts of Human Rights, A," *Afr. Hum. Rts. LJ* 2(2002). 196

<sup>559</sup> K. Hopkins, "Effect of an African Court on the Domestic Legal Orders of African States," *Afr. Hum. Rts. LJ* 2(2002). 251

### 3.8.2.3.2 The Use of the Commission by Libyan Citizens

It is important to remember that Libya signed and ratified the African Charter on Human and People's Rights in 1987 and, as already mentioned above, the Commission was established in the light of this Charter. Thus, the Libyan government is required by the principles of international law to implement the commitments made in the Charter.

In international law, ratification of a particular Charter means that there are two anticipated outcomes. Firstly, the authorities of the state, including the judicial branch, are required take the international obligations that result from that treaty into account when they act. Secondly, if the Libyan government fails to enforce these obligations by itself, citizens can challenge the state, especially in the case of the African Charter where there is a monitoring body that exists to ensure and monitor the accomplishment of the rights and duties which are included in the treaty. Given this, the Commission is considered one of the most flexible regional human rights mechanisms. For example, according to Wachira, the Commission has the ability to entertain complaints from anyone concerning breaches of human rights by a state party.<sup>560</sup>

Given this, there are theoretically good opportunities for individuals, as well as Libyan human rights organizations, to file complaints against their country or any other state party that breaches human rights commitments. Therefore, if the government does not vindicate the right to health care, as expressed in article 16 of the African Charter, it should be aware that citizens can seek to obtain this right, or at least embarrass the state, by utilizing this mechanism.

Indeed, the Commission has played a fundamental role in the protection of human rights in several African states, such as Nigeria, South Africa and Cameroon, when it was utilized by citizens of these states using NGOs that represented them in front of the Commission. In Nigeria, for example, the actions of the Nigerian authorities, including the courts, were impacted upon by the African Commission's perspective.<sup>561</sup> However, some writers are displeased with the Commission's role in the African human rights scene.<sup>562</sup> Nonetheless, while the role of the Commission is still limited, it nonetheless has the potential to improve the human rights situation in Africa.

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<sup>560</sup>Wachira, *African Court on Human and Peoples' Rights: Ten Years on and Still No Justice*. 9

<sup>561</sup>G.J. Naldi, "Interim Measures of Protection in the African System for the Protection of Human and Peoples' Rights," *African Human Rights Law Journal* 2(2002). 6-8

<sup>562</sup>O.C. Okafor, *The African Human Rights System, Activist Forces and International Institutions* (Cambridge University Press, 2007). 221-272

At the moment, the African Commission, as will be discussed below, seems to be the only direct human rights mechanism that could be used by Libyan citizens to persuade their government to fulfil its national and international human rights commitments. However, the decisions of the Commission are not binding on states, although they do have the power to embarrass the government and perhaps provide an incentive to improve its health policy in ways that make it more capable of meeting its human rights obligations. In addition, courts can avoid unnecessary embarrassment by relying on the recommendations of the African Commission when they examine any human rights case.

#### **3.8.2.4 The African Court of Justice and Human Rights**

The human rights system seems unclear about the sort of court that needs to be established in order to consider any disputes or cases in relation to human rights in the region. In 1998 the Court was formally named the African Court on Human and People's Rights. In 2008, the Court was re-established in a new form that combined the African Court on Human and People's Rights<sup>563</sup> with the African Court of Justice<sup>564</sup> to create a single court that is now called the African Court of Justice and Human Rights.<sup>565</sup> Consideration of the African Court will focus on two areas; firstly, the thesis will provide general details about the court concerning its creation, membership and competence and, secondly, it will consider the accessibility of the Court. So far, the Court has only dealt with two cases - one concerning the Libyan government's violation of the right to peaceful protest in the country.<sup>566</sup> Thus, this discussion will be largely speculative as to the impact that the Court could have on human rights.

##### **3.8.2.4.1 General Information about the African Court**

Because the protocol of 2008 is still awaiting signature and ratification by the African states, this discussion of the Court will concentrate on the text of the protocol rather than

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<sup>563</sup> The African Union, Protocol to the African Charter on Human and Peoples' Rights on the Establishment of an African Court on Human and Peoples' Rights available at [http://au.int/en/sites/default/files/PROTOCOL\\_AFRICAN\\_CHARTER\\_HUMAN\\_PEOPLES\\_RIGHTS\\_ESTABLISHMENT\\_AFRICAN\\_COURT\\_HUMAN\\_PEOPLES\\_RIGHTS\\_1.pdf](http://au.int/en/sites/default/files/PROTOCOL_AFRICAN_CHARTER_HUMAN_PEOPLES_RIGHTS_ESTABLISHMENT_AFRICAN_COURT_HUMAN_PEOPLES_RIGHTS_1.pdf) accessed on 15/03/2009

<sup>564</sup> The African Union, Protocol of the Court of Justice of the African Union, available on line at [http://au.int/en/sites/default/files/PROTOCOL\\_COURT\\_OF\\_JUSTICE\\_OF\\_THE\\_AFRICAN\\_UNION.pdf](http://au.int/en/sites/default/files/PROTOCOL_COURT_OF_JUSTICE_OF_THE_AFRICAN_UNION.pdf) last accessed 16/11/2009

<sup>565</sup> The African Union, Protocol on the Statute of the African Court of Justice and Human Rights, article 2, 2008, available on line at <http://www.africa-union.org/root/au/Documents/Treaties/text/Protocol%20on%20the%20Merged%20Court%20-%20EN.pdf> accessed 16/11/2009

<sup>566</sup> B. Szewczyk, "The African Human Rights System," *The Rules, Practice and Jurisprudence of International Courts and Tribunals*, Chiara Giorgetti, ed., Kluwer/Brill (2011). 15- 18

on its actual usage. According to article 3 of the Statute of the African Court of Justice and Human Rights (the Statute), the Court shall consist of sixteen judges who shall be citizens of states parties (there were eleven judges under the previous protocol.)<sup>567</sup> There must be no more than one judge from each member state.<sup>568</sup> In addition, it was proposed that where possible judges should be drawn from all areas of the continent.<sup>569</sup> As in other international courts, the judges are independent and must meet the qualifications required in their respective states for selection to the highest judicial offices. They shall be experienced, with recognized competence in international law or human rights law. The judges of the Court should have appropriate experience in dealing with human rights, either in the courts or in academic institutions.

The statute states that the election of the judges shall be undertaken by the Executive Council and assigned by the Assembly in a secret ballot by a two-thirds majority of member states with voting rights. The Assembly shall ensure equitable geographical representation and equitable gender representation on the Court.<sup>570</sup>

Because the African Union decided to establish a single Court to deal with both justice and human rights matters in the region, instead of having two courts as was the situation before 2008, the single Court has been divided into two sections: a General Affairs section and a Human Rights section.<sup>571</sup> Each section has eight judges and can have one or more Chambers. The Statute states that the Court can meet in ordinary as well as extraordinary sessions. The latter can be convened by the President or at the request of the majority of the judges.<sup>572</sup>

In terms of the jurisdiction of the Court, especially in relation to human rights, the Court can deal with all cases and legal disputes and, in accordance with article 28, it shall specifically cover the following points: "... c) the interpretation and the application of the African Charter, the Charter on the Rights and Welfare of the Child, the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, or any other legal instrument relating to human rights, ratified by the States Parties concerned; d)

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<sup>567</sup> Article 3, para 1

<sup>568</sup> Article 3, para 2

<sup>569</sup> Article 3, para 3

<sup>570</sup> Article 5

<sup>571</sup> Article 16

<sup>572</sup> Article 20

any question of international law; e) all acts, decisions, regulations and directives of the organs of the Union ...”.<sup>573</sup>

In regard to the jurisdiction of the Court, there are two types of power that it can exercise. Firstly, it has a judicatory power. Under this authority, the judgements of the Court are obligatory and final and not subject to an appeal except in the event of new evidence from the states parties.<sup>574</sup> Secondly, the Court can give an advisory opinion on any legal question at the request of the Assembly, the Parliament, the Executive Council, the Peace and Security Council, the Economic, Social and Cultural Council (ECOSOCC), the Financial Institutions or any other organ of the Union as may be authorized by the Assembly in accordance with article 53 of the Statute.<sup>575</sup>

According to article 30 of the Statute, individuals in Africa are only authorized to submit cases to the Court in relation to any violation of a right guaranteed by the African Charter or by any other regional or international legal human rights instrument ratified by the states parties concerned.<sup>576</sup> It is important to note that the right of an individual to submit a case to the Court is dependent on a declaration by his or her state confirming that it accepts the competency of the Court to deal with the cases submitted by individuals.<sup>577</sup> In addition, article 30 covers other entities such as states parties to the current Protocol, the African Commission on Human and People’s Rights, the African Committee of Experts on the Rights and Welfare of the Child, the African Intergovernmental Organizations accredited to the Union or its organizations, the African National Human Rights Institutions, and individuals or relevant non-governmental organizations which are entitled to submit cases to the Court.<sup>578</sup>

It can, therefore, be anticipated that the establishment of the African Court of Justice and Human Rights could play a fundamental role in the promotion and protection of human rights in the region, especially if permission is given to individuals to submit cases directly to the Court. It is important, at this stage, to explore how Libyan citizens might utilize the

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<sup>573</sup> Article 28

<sup>574</sup> Wachira, *African Court on Human and Peoples' Rights: Ten Years on and Still No Justice*. 23

<sup>575</sup> Article 53 para 2 and 3

<sup>576</sup> African Union, Protocol on the Statute of the African Court of Justice and Human Rights, Article 30/f available at <http://www.africaunion.org/root/au/documents/treaties/text/Protocol%20on%20the%20Merged%20Court%20-%20EN.pdf> accessed on 27/09/2012,

<sup>577</sup> Article 8 of the Protocol, G. Bekker, "Recent Developments in the African Human Rights System 2008–09," *Human Rights Law Review* 9, no. 4 (2009). 674

<sup>578</sup> Article 30

Court and the potential impact of this on human rights in Libya, as well as in the region as a whole.

#### **3.8.2.4.2 The Opportunity of Libyan Citizens to Submit Cases to the Court**

Under the present protocol, as was also the case under the previous protocol, an individual has no right to submit a case directly to the Court unless the state party concerned has accepted the competence of the Court to hear them under Article 30 (f). As Mutua has said, “Individuals and NGOs cannot bring a suit against a state unless two conditions are met. First, the Court has discretion to grant or deny such access. Secondly, at the time of ratification of the Draft Protocol or thereafter the state must have made a declaration accepting the jurisdiction of the court to hear such case.”<sup>579</sup> Unfortunately, the Libyan government has not yet made such a declaration. Indeed, so far only two African states, Burkina Faso and Mali, have made this declaration permitting individuals and NGOs to have direct access to the Court.<sup>580</sup>

The above situation, however, does not mean that individuals are completely denied access to the Court. In fact, an individual can indirectly have access to the Court via the African Commission. According to Article 30 of the Statute, the African Commission can submit any case that has been presented to it by individuals or NGOs to the Court if the Commission has seen a real violation of human rights that cannot be rectified using its limited powers. The Commission may transfer cases to the African Court, where it feels that the case requires adversarial adjudication rather than an amicable settlement.

#### **3.8.3 The Right to Health Care and the UN Human Rights System**

As a socioeconomic right, the right to health care may be monitored by other international bodies which are responsible for examining how the states parties of the particular treaty implement its rules and decide on whether or not they have satisfied the international standards of that treaty. It has already been argued that the language used in international treaties is, however, too vague to identify the core of any rights in health and healthcare. Therefore, this discussion will proceed using the language of the ‘right to health care’ as argued for in this thesis.

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<sup>579</sup>M. Mutua, "The African Human Rights System: A Critical Evaluation," (Human Development Report Office (HDRO), United Nations Development Programme (UNDP), 2000). 28 available at <http://hdr.undp.org/en/reports/global/hdr2000/papers/MUTUA.pdf> accessed 15/03/2009B. Szewczyk, "The African Human Rights System," *THE RULES, PRACTICE, AND JURISPRUDENCE OF INTERNATIONAL COURTS AND TRIBUNALS*, Chiara Giorgetti, ed., Kluwer/Brill, 2011 (2011). 11

<sup>580</sup>Wachira, *African Court on Human and Peoples' Rights: Ten Years on and Still No Justice*. 13

Because the right to health care has been mentioned (albeit using different language) in several international conventions such as the UDHR, the ICCPR, the ICESCR, the CEDAW, CAT, the CRC, ICRMW and many other international conventions and protocols, and because each of these conventions has established a monitoring body, a full consideration of these many and varied conventions will not be undertaken. Rather, an examination here of the international monitoring bodies will focus on that most relevant to the right to health care; namely, the International Committee on Economic, Social and Cultural Rights (CESCR).

### **3.8.3.1 International Committee on Economic, Social and Cultural Rights**

While the ICESCR was adopted in 1966 and entered into force in 1976, the Covenant did not include any text in regard to the establishment of a treaty body.<sup>581</sup> In fact the treaty body of the ICESCR was established ten years later by the UN Economic and Social Council. From 1976 the UN Economic and Social Council performed its duties under article 16 of the Convention and established a fifteen member working group, appointed by governments. However, this body was criticized on the grounds that instead of focusing on the legal issues of human rights it concentrated on the political angle of human rights.<sup>582</sup>

In 1985, the Economic and Social Council (ECOSOC) established the Committee on Economic, Social and Cultural Rights (CESCR) which held its first session in 1987.<sup>583</sup> There are eighteen members elected by ECOSOC from a list submitted by states parties. The term of membership is four years and half of the committee members are renewed every two years. In accordance with resolution 1985/17, all geographical areas shall be represented on the Committee. Although appointed by states, each member is required to act independently and not as a state representative.<sup>584</sup>

The function of the Committee is to examine the reports that states are obliged to submit under article 16 of the ICESCR to the Committee, via the Secretary General of the United Nations, who shall transmit copies of these reports both to the ECOSOC and the relevant UN specialized agencies.<sup>585</sup> In addition, the Committee has the power to issue non-binding

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<sup>581</sup>Rehman, *International Human Rights Law: A Practical Approach*. 124

<sup>582</sup>Coomans, "Economic, Social and Cultural Rights." 7, M. Craven, "The Un Committee on Economic, Social and Cultural Rights," *Economic, Social and Cultural Rights: A Textbook* (2001). 459-60

<sup>583</sup>ECOSOC Resolution. 1985/17 (1985)

<sup>584</sup>Craven, "The Un Committee on Economic, Social and Cultural Rights." 459-60

<sup>585</sup>Henkin, "International Human Rights as "Rights"." 431

general comments which can be used by states as guidelines for implementing socioeconomic rights. In its first general comment, the Committee clearly explained the aims and objectives of the state reporting system as follows:

It would be incorrect to assume that reporting is essentially only a procedural matter designed solely to satisfy each State party's formal obligation to report to the appropriate international monitoring body. On the contrary, in accordance with the letter and spirit of the Covenant, the processes of preparation and submission of reports by States can, and indeed should, serve to achieve a variety of objectives.<sup>586</sup>

The Committee used general comment No. 14 to explain the outline of the right to health care (which is known internationally as the right to health) and the obligations of states in respect of that right and its implementation. This right has also benefited from other general comments; for example, general comment No 19 referred to health care as a main principle of social security.<sup>587</sup> Additionally general comments No 3, 5, 8, 15, 16 and 18 indirectly engage with the right to health care.

In regard to reporting procedures, the Committee uses similar techniques to those of the Human Rights' Committee; however, the Committee on Economic, Social and Cultural Rights is responsible to the ECOSOC rather than the states parties as is the Human Rights' Committee. Therefore, there is no need to discuss how the reporting system works because books on human rights have explained this reporting system procedure.<sup>588</sup>

In terms of socioeconomic rights in Libya, and particularly the right to health care, the Committee has commented on several reports which were submitted to it by the Libyan government. In its concluding observations in 2006, for example, the Committee emphasized in most of the paragraphs that it had not received clear or sufficient information from the Libyan government.<sup>589</sup> Thus, improving the reporting system as a method of ensuring the implementation of social and economic rights needs to be taken seriously by the states parties if the Committee is to operate effectively and appropriately. In its attempts to make its work more useful, the Committee has authorized itself to issue General Comments similar to the Human Rights Committee (HRC). As explained above,

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<sup>586</sup> CESCR, General Comment No 1, Reporting by States parties, Third session, 1989, Para 1

<sup>587</sup> See the general comment No 10 E/C.12/GC/19, <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G98/148/41/PDF/G9814841.pdf?OpenElement> accessed on 26/04/2012

<sup>588</sup> For instance see Craven, "The Un Committee on Economic, Social and Cultural Rights." 461-65

<sup>589</sup> See the ECOSOC, E/C.12/LYB/CO/2 on 25 January 2006, <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G06/402/15/PDF/G0640215.pdf?OpenElement> accessed on 02/06/2009

the first General Comment is on reporting by the States Parties, what the report shall include and how it can be presented. This can be called an innovative procedure.<sup>590</sup>

In order to achieve its aims, the Committee has tried a variety of strategies to assist states parties to meet their goals. For example, the Committee has worked closely with NGOs and UN specialized agencies. In the case of the NGOs, the cooperation between the Committee and the NGOs was successful on several counts; the NGOs submitted essential information about how the states parties treat the rights in the Convention. Reports submitted by these non-governmental organisations allowed the Committee to consider the situation of rights and develop its work in certain areas such as the discussion about the right to housing.<sup>591</sup>

Another positive achievement of the Committee's efforts arose from its close association and coordination with UN agencies. In its general comment, the Committee explained how the specialised agencies can help states parties in implementing the ESC rights; notably the right to education. The Committee also pointed out that international organisations are required to take into account these rights in their policies and programmes.<sup>592</sup> In respect of issues such as HIV/AIDS, the Committee cooperated with the WHO to discuss human rights issues in respect of people living with HIV/AIDS.<sup>593</sup>

The success of the Committee in making concluding observations, making suggestions about the states parties' reports as well as issuing useful general comments with the aim of clarifying the legal position of ESC rights, socioeconomic rights such as right to health care might be shaped as real human right but this may need time. The Committee also began to contemplate the creation of an optional protocol which gives individuals and states similar opportunities to make complaints if their social and economic rights are violated. After several drafts, the Committee adopted a draft in its fifteenth session in

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<sup>590</sup>Rehman, *International Human Rights Law: A Practical Approach*. 128

<sup>591</sup> See examples of this cooperation in S. Leckie, "The Committee on Economic, Social and Cultural Rights: Catalyst for Change in a System Needing Reform," *The Future of UN Human Rights Treaty Monitoring* 129(2000). 133-141; Matthew. Craven, "The Un Committee on Economic, Social and Cultural Rights," in *Economic, Social and Cultural Rights*, ed. Asbjorn. Eide, Catarina. Krause, and Allan. Rosas (London: Martinus Nijhoff Publishers, 2001).

<sup>592</sup>F. Coomans, "The Extraterritorial Scope of the International Covenant on Economic, Social and Cultural Rights in the Work of the United Nations Committee on Economic, Social and Cultural Rights," *Human Rights Law Review* 11, no. 1 (2011).18; Sofia Gruskin et al., *Perspectives on Health and Human Rights* (Routledge Taylor & Francis Group

2005).18

<sup>593</sup> See International Guidelines on HIV/AIDS and Human Rights 2006 available at <http://www.ohchr.org/Documents/Publications/HIVAIDSGuidelinesen.pdf> accessed 19/07/2012

1996.<sup>594</sup> In 2008, the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights was adopted by the General Assembly.<sup>595</sup>

In the terms of article 2 of the Protocol, the Committee can receive communications by, or on behalf of, individuals or groups of individuals. The Committee cannot consider a communication unless all available domestic remedies have been exhausted.<sup>596</sup> Most importantly, the Committee cannot deal with a communication against a state which is not party to the Protocol even if it was a state party to the Covenant. In other words, being a state party of the Covenant does not automatically mean that the state is a state party to the Protocol.<sup>597</sup>

In general, the Protocol was copied from the First Optional Protocol on Civil and Political Rights, but there are a number of important differences.<sup>598</sup> For example, in the terms of the Protocol the Committee is authorized to conduct a confidential inquiry<sup>599</sup>. Unless the Libyan state ratifies the new Protocol, it seems that there is no direct instrument that can be employed by Libyan citizens to make complaints against the state. In general, however, the adoption of the Protocol by the General Assembly was a critical development that may encourage the government of Libya to sign and ratify the Protocol as soon as possible. In fact, since the Libyan government has ratified most international human rights conventions, it is reasonable to expect that it will also ratify this important Protocol. Until then, however, for Libyans, the only way to express their dissatisfaction with the approach to socioeconomic rights, including of course the right to health care as proposed in this thesis, will be through the role of NGOs in the reporting system.

In Libya, the promotion and protection of human rights is primarily the responsibility of the domestic authorities, including the courts. The undertaking of responsibility by the courts is of increasing importance if citizens are to be able to enjoy their human rights. Libyan authorities, particularly the judiciary, must promote the culture of human rights in society, allowing citizens to be aware of their rights on the one hand and, on the other, the judiciary should encourage the government to ratify and implement human rights without any hesitation due to political or financial reasons.

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<sup>594</sup>Craven, "The Un Committee on Economic, Social and Cultural Rights." 469

<sup>595</sup>The General Assembly adopted resolution A/RES/63/117, on 10 December 2008, [http://www2.ohchr.org/english/law/docs/A.RES.63.117\\_en.pdf](http://www2.ohchr.org/english/law/docs/A.RES.63.117_en.pdf), accessed on 26/04/2012

<sup>596</sup> Article 3

<sup>597</sup> Article 1

<sup>598</sup>Craven, "The Un Committee on Economic, Social and Cultural Rights." 469-470

<sup>599</sup>T.J. Melish, "Introductory Note to the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights," *ILM* 48(2009). 7-8

Despite the fact that a right similar to that proposed in this thesis appears in Libyan law, it can be seen that it has not been treated seriously. There may be a number of reasons for this. First, there is no culture of human rights in Libya, whether in respect of social and economic or civil and political rights. It is, of course, possible that the new Libyan regime will change this situation. Secondly, and arguably of critical importance, the courts have been unwilling to play a significant role in protecting any right to health care.

Even in the absence of a legislative or constitutional right to health care (however defined), it is possible to vindicate claims in this area. As has already been suggested, justiciability is the key to ensuring the adequate provision of health care, and the following chapter will discuss how the ability to challenge state provision, and the willingness of courts to accept jurisdiction over such cases, has impacted on the rights of citizens in the United Kingdom. Attention will be paid to both UK and relevant European jurisprudence.

# **Chapter IV: The Right to Health**

## **Care in England**

## 4.1 Introduction

In the previous chapter, it was shown that in Libya a right to healthcare has been theoretically, but not practically, embraced. In this chapter, the focus is on the position of the right to health care in the English legal system and the question to be addressed is whether or not the model that emerges could be a valuable basis for health care reform in Libya. It is important to clarify that there are slight differences in health care services between the different regions of the UK. For instance, there are differences in health care services between England and Scotland; however, these are only minor differences. This study will focus on health policies that are produced by the central government in reference to UK health care services in general.

As is well known, health care has acquired a significant position in UK governmental policies especially since the Second World War and the enactment of the National Health Service Act of 1946. Under this Act, and its amendments in the following years, it became the responsibility of the state to provide health care to all citizens and to give citizens a sense of confidence that they can challenge the decision of the health authorities if they think that some aspect within the health care remit is not as it should be. Thus, health care is not only a social service or aid offered to poor people but it is also a legal right.

In this chapter, there will be a spotlight on the right to health care under the English legal system. To do so, the chapter will be divided into five sections; the first will introduce the legal development of the health care system in the UK. In the next section, the concept of the right to health care in England will be defined and explained. This will be followed by how English courts have dealt with the right to health care and the influence of the Human Rights Act of 1998 on understanding of human rights in general and, in particular, the right to health care. In this section, the relationship between Parliament and the courts is also explained in order to show what courts can do in terms of the justiciability of the right to health care. In the last two sections, the study will focus on the cases of the right to health care in both domestic courts and in European institutions (Council of Europe and European Union), including the European courts, and how they have treated health care cases and interpreted the law in each case.

Within this context, it is important to mention that cases are usually brought to the European courts if the claimant has not been satisfied with the judgment of the English courts. Inevitably, this invites a certain amount of repetition. In order to avoid this, domestic cases are discussed in this thesis without making any direct connection between

English judgments and the decisions of European courts (the European Court of Human Rights (ECtHR) or the European Court of Justice (ECJ)).

## 4.2 Legal Development of Health Care in the UK

The Beveridge Report<sup>600</sup> proposed that health care should be nationalised with the aim of bringing an end to inequalities, to problems in the construction of hospitals' systems and to tackle the lack of access to health care faced by many of the population, especially children, women and old people. In addition, there had been difficulties with the allocation of resources and a lack of coordination at the administrative level. These were all concerns that preceded the creation of the National Health Service (NHS) in 1946. The Beveridge Report concluded, in its recommendations, that the nationalisation of health care was inevitable and that the reconstruction of health authorities and institutions was required to rebuild social security in the country.<sup>601</sup>

Since then, health affairs have become a public concern and not just a matter of political propaganda. Moreover, one can say that, worldwide, health care has become positioned, legally, economically and politically at the top of the social agenda in most countries, irrespective of political ideology, religious beliefs or economic growth. It will be seen in this section how health care has become a major subject in British life, in spite of all the difficulties that may have an effect on the implementation of the right to health care in reality. From the perspective of this discussion, this concern about health care can be dated back to the post-war era when government wanted to maximise workforce capacity, in parallel with its need to take care of injured people (civilians or military) who are unable to pay for treatment. It could be argued that the government was obliged by the outcomes of the war to set in place this radical model.

To explore this change in the perception of the importance of health care, this subsection briefly trace the history of the NHS and highlight the most significant improvements that reflected positively or negatively on the concept of health care as a legal right. It is not intended to provide a detailed discussion on the history of health care in Britain; rather, this section will set the context within which the focus will be on the significant developments that have contributed to the status of health care as a legal or human right. To do so, the

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<sup>600</sup>Sir William Beveridge, *Social Insurance and Allied Services*, November 1942, HMSO, CMND 6404 available at <http://www.sochealth.co.uk/public-health-and-wellbeing/beveridge-report/> accessed on 01/10/2012

<sup>601</sup>Christopher Ham, *Health Policy in Britain*, 5 ed. (Palgrave Macmillan 2004). 13

period of 1945 until the present is used. This brief history will show how health policy developed from workers' insurance and social aid provided to poor people into a legal right, although this is a relatively short period in Britain's long history, there were considerable improvements in health care during this period. These improvements were not only related to scientific progress but also to the legal concept of health care in general.<sup>602</sup>

The aim of this section is to show how, in the period under consideration, the government planned to provide free access to free health care for all, irrespective of the ability to pay. At the same time, the difficulties of such plans will be highlighted and the expectations of citizens will be discussed in terms of human rights: in particular, the right of access to health care, equity, choice, medication and, most importantly, the legal basis of the right to health care since the enactment of the National Health Services Act 1946. This section will discuss the period in the three following sections: the first subsection will cover 1945 to 1973; the second part will cover the era between 1974 and 1996, and finally, the third subsection will cover the period from 1997 until the present. These dates were selected because of the major reorganisations or changes that occurred in the NHS between these dates. It is important to note that this part will focus mainly on the English health care system where the NHS started and have seen most of the developments. It is also significant to note that this selection build on avoidance any confusion might be resulted if this discussion covered the Scotland and North Ireland NHS systems too.

#### **4.2.1 Status of Health Care as a Public Service**

Before 1948, the provision of health care services was not free and not comprehensive; thus it was not available to all citizens and was only offered freely to poor and old people under the Poor Law Amendment Act 1868 and then Local Government Act 1929.<sup>603</sup> Before the National Health Service Act, the state was not responsible for providing a free and comprehensive health service for the population. Only in the case of spreading epidemic diseases would the government provide free preventive health care. The NHS Act opened the door to all citizens, giving them access to comprehensive health care, that is, both preventive health care and therapy, free of charge. Put another way, prior to the NHS Act,

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<sup>602</sup>For the history of national health care in Britain see V. Berridge, *Health and Society in Britain since 1939*, vol. 38 (Cambridge Univ Pr, 1999). D. Childs, *Britain since 1945: A Political History* (Taylor & Francis, 2006). 14-16, and C. Webster, *The National Health Service: A Political History* (Oxford, 2002). See also I. Greener, *Healthcare in the UK: Understanding Continuity and Change* (Policy Pr, 2008). 13-37

<sup>603</sup>Ham, *Health Policy in Britain*. 11

health care was not a legal right. Instead, it was viewed as a charitable action for poor people or as insurance right for workers.<sup>604</sup>

In 1946, the National Health Service Act was enacted, entering into force two years later, making the UK the first western country to provide free health care to the whole population. The importance of this event was that it became a 'legal duty' of the state to provide health care services free of charge at the point of delivery to all British citizens. Access to health care no longer depended on people's means, or on the Poor Laws, or on charitable activities provided to disadvantaged people in the country.<sup>605</sup> With the NHS Act, health services become a state responsibility. Although the service provided was not immediately improved in reality, as noted by Sir Codber's report<sup>606</sup>, health services began to be part of public policy in the UK.

In a legal sense, the state became responsible for the provision of health care and health services now had a place in the annual budget. This meant that Parliament had to allocate financial resources from public funds to pay for the health care service. To allow the Secretary of State for Health to succeed in his duty, the NHS Act established a new independent national body to be supervised by the Secretary of the State for Health; namely the National Health Service. Under this new umbrella, doctors, nurses, hospitals, dentists, opticians and pharmacists were brought to work together for the first time.<sup>607</sup> Finance has always been a constant topic of debate since the creation of the NHS. However, the Guillebaud Report,<sup>608</sup> into the cost of the NHS in general, concluded that it was not as extravagant as some had originally thought. On the contrary, the Report showed that, in many respects, the NHS offered good value for money; in fact, it recommended that the government allocate more money to the NHS which would allow it to build new hospitals.<sup>609</sup> The government was facing criticism for making doctors

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<sup>604</sup>D. Porter, *Health, Civilization, and the State: A History of Public Health from Ancient to Modern Times* (Psychology Press, 1999). 145 and R. Fitzpatrick, R. Surender, and T. Chandola, "Health and Health Care," *Britain Since 1945* (2008). 332-333

<sup>605</sup>C. Hogg, *Citizens, Consumers and the Nhs: Capturing Voices* (England ; New York: Basingstoke: Palgrave Macmillan, 2009).12.

<sup>606</sup> According to Sir Codber "there were forebodings of chaos on the Appointed Day but, in the event, on 5 July 1948 services were given to patients just as they had been during the previous week". Webster, *The National Health Service: A Political History*.28-29

<sup>607</sup>To understand the role of the war in establishing of the National Health Services in Britain and its implications on social policy in the UK in general see K. Jefferys, "British Politics and Social Policy During the Second World War," *The Historical Journal* 30, no. 1 (1987). 123-44

<sup>608</sup>C.W. Guillebaud, "The Cost of the National Health Service," (London: House of Commons, 1956).

<sup>609</sup>T. E. Chester, "The Guillebaud Report," *Public Administration* 34, no. 2 (1956). 200-2 see also Webster, *The National Health Service: A Political History*.32-33

practice twentieth-century medicine in nineteenth -century buildings.<sup>610</sup> Thus, there was a requirement for increasing expenditure. In response, the government adopted the 1962 Hospital Plan with an expenditure of £500 million in England and Wales. The aim of this plan was the construction of District General Hospitals (DGH) of 600 to 800 beds each, in different regions of the country.<sup>611</sup>

Implementing the National Health Service Act in 1948 gave rise to the need for rearrangement of the relationship between the Ministry of Health, local authorities and the NHS body, on the one hand, and the specialists and GPs, on the other. As a result of these new arrangements, the Minister of Health at that time, Aneurin Bevan, the so-called ‘father’ of the National Health Service in Britain, opened negotiations with various parts of the health services to explain the new health service plan and to set out how the different sectors, and the population as a whole would benefit from it. He succeeded in gaining the support of the hospitals. This resulted in his gaining significant widespread support and helped to reduce the power of the GPs, who were nevertheless successful in accomplishing many of their targets such as independence from local authority control and a minimum salary for all.<sup>612</sup>

In 1952, in order to reduce the huge costs incurred by the health service, the government introduced prescription charges; in 1965, however, they were abolished. This abolition was important in allowing the NHS to return to its general principles – that is, free access to health care for all, regardless of one's means. This reconsideration is important in showing the insistence of respect for this main principle of the NHS.

In the 1960s, the structure of the NHS administration was criticised by several reports and documents published by health authorities including the Ministry of Health and other committees.<sup>613</sup> To tackle overlap, duplication and lack of co-ordination between the three parts of its structure, the government set out proposals for reorganisation of the service. These proposals, discussed below, were not accepted until 1974. Here, it is important to note that the NHS was not only facing a structural problem but was also facing problems concerning the distribution of powers and responsibilities between health authorities. As a result, there was an essential contradiction at the heart of the NHS. Therefore, the

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<sup>610</sup>Webster, *The National Health Service: A Political History*.40 also see Ham, *Health Policy in Britain*. 17

<sup>611</sup>Ham, *Health Policy in Britain*. 17

<sup>612</sup>Ibid. 14, see also Rudolf Klein, *The New Politics of the Nhs*, 3 ed. (Longman, 1995). 13

<sup>613</sup>Ham, *Health Policy in Britain*.15-26

government began to consider how to redistribute powers and responsibilities between all sectors, in a way that would lead to an effective and constructive system.

There are several general comments that can be made in respect of the positive impact of the establishment of the National Health Service. The first is that the UK government started to deal with health care services as part of their political and legal responsibility towards their citizens. Thus, after 1948, health care came top of the agenda for all British political parties, irrespective of their ideology; the provision of health services to citizens became a legal duty.

The second is that the provision of free health care became a part of general national policy. Thus, there is no disagreement about the status of health services, post-NHS Act, and discussion about health services following the enactment of the National Health Service Act has focused on its financial foundations, or on how health care delivery could be improved. The establishment of the National Health Service was, without doubt, useful in showing how the state could co-ordinate the health care system.

The third general comment on the NHS Act of 1948 is that Britain succeeded in bringing all of the medical professions to work together, not only for their own interests, but also for the interests of the whole nation. By negotiation with GPs, hospitals, specialists and local authorities, the Minister of Health was able to create a tripartite structure that encompassed all the bodies responsible for delivering and administering health care to the population.<sup>614</sup> However, it soon became evident that the tripartite structure was not practicable; as will be seen later, this structure was to become the subject of many statutory and governmental attempts to improve how health services were delivered.<sup>615</sup>

The fourth general comment about the importance of health care is that the citizen was able to consider health care as a statutory right. Since the introduction of NHS legislation, health care was provided to all free of charge and without conditions (such as being poor, old or disabled); in addition, health care services included both preventive and curative health care. As will be shown later in this chapter, UK citizens rely on the Health Service Act to claim their health care rights, using all the available mechanisms such as the NHS complaints system or by resorting to the courts whenever they feel dissatisfied with the service received. Thus, health care became not only a free service, but a legal right in the

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<sup>614</sup>For more information about this structure see Rob Baggott, *Health and Health Care in Britain*, 3 ed. (Palgrave Macmillan, 2004). 86-88,

<sup>615</sup>*Ibid.* 89

UK. To clarify, British citizens became not just mere recipients of the service but also decision-makers. This will be expanded upon later.

Recently, although the European Convention on Human Rights does not include any provision directly related to health care, the European Court of Human Rights has used its interpretive authority, as will be seen later, to make the indirect link between the right to health care and the right to life.<sup>616</sup> In recent cases such as *D v United Kingdom*, the ECtHR had held that in exceptional circumstances protection of health care needs to be considered to avoid threaten or loss of life. In addition, the Council of Europe adopted the European Social Charter in 1961, which was revised in 1996. Under this Charter, health protection has been clearly declared in its articles 11 and 13. It is significant to note that although the revised Charter entered into force in 1999, the UK has not yet to ratify it<sup>617</sup> however it is worth to mention that the UK government has some obligations in light to the original ESC of 1961 which some of its chapters ratified by the UK.<sup>618</sup> Importantly, these instruments, associated with the International Convention on Economic, Social and Cultural Rights, indicate the beginning of the indirect trend of accepting health care as a human right in Europe; moreover, they have played an essential role in achieving such acceptance.

It is perhaps significant that the relevant provisions in the NHS Act are framed in terms of duties of the government rather than rights of the population. Thus, the state had wider discretionary powers in relation to the provision of health care following the enactment of the NHS Act, in comparison to the 1980s and beyond, as will be explained later. However, from the start, all successive governments have tried their best to improve health services. This is demonstrated by their efforts to suggest new plans, the building of new hospitals and the modernising of medical equipment.

In short, one can say that the establishment of the NHS posed a great challenge to the British government, especially because it came immediately after the Second World War. In relation to the philosophy of health care, the NHS Act considered health service as a 'legal right' of every British citizen, regardless of their economic status. Such a notion was a considerable step in creating a new view of the relationship between state and citizen. As

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<sup>616</sup>Brems, "Indirect Protection of Social Rights by the European Court of Human Rights." Sellin, "Justiciability of the Right to Health: Access to Medicines-the South African and Indian Experience." and Tinta, "Justiciability of Economic, Social, and Cultural Rights in the Inter-American System of Protection of Human Rights: Beyond Traditional Paradigms and Notions." See also the Keenan versus UK case

<sup>617</sup> See for example A. Maclean, *Briefcase on Medical Law* (Routledge Cavendish, 2001). 178

<sup>618</sup> Details of the role of the ESC in protecting social right in Europe can be seen in M. Khemani, "The European Social Charter as a Means of Protecting Fundamental Economic and Social Rights in Europe: Relevant or Redundant?," *Available at SSRN 1606110* (2009).

will be explained, it also played a fundamental role in the reconsideration of the classification of health as a political matter or as a legal matter. As will be seen in the following section, the NHS Act gave a platform on which citizens could have their voices heard, allowing them to challenge the health authorities' decisions and enforce what they believed to be their legal right, irrespective of the availability of financial resources. Therefore, one can say that the justiciability and enforceability of the legal right to health care in the UK are directly linked to the enactment of the NHS Act in 1948.

#### **4.2.2 Health Care Between Market and Choices**

Since its creation, the NHS has attracted considerable attention from different British governments, whether Labour or Conservative. As mentioned above, the health care system in the UK has suffered from administrative, structural and financial problems

In the 1980s the focus was more on how to improve the quality of service and the means of delivery to the citizen than on cost, though this was still a potential concern. As Hogg pointed out "The NHS was based on every citizen having social rights, and citizens were entitled to benefits, such as free healthcare, which were not charity."<sup>619</sup> Thus, the health authorities started to take into account the expectations of citizens in respect of the services provided by health bodies. In order to meet these expectations and to minimise the shortcomings of the health institutions – these being institutional, financial and organizational and in respect of relations between the NHS and its beneficiaries – health policy changed quickly and permanently. For these reasons, in 1974, efforts were made to introduce more lay involvement, which aimed to accomplish greater responsibility towards the public and increase their share in the NHS.

The idea that the patient should be the focus of the health services has its roots in the establishment of Community Health Councils (CHCs), set up in 1974, as a means of representing the concerns of local people to managers of the NHS. In general, the reorganisation of the NHS can be linked to a change in the philosophical approach to the citizen-state relationship; in other words, the views of patients were not considered significant, since they were only recipients of services. Arguments about patients' rights began to call into question the power of professionals. Given this, there was a need for reorganisation of the NHS.

The reorganisation of the NHS aimed to achieve three main goals. The first was to integrate health services under one body that would have overall control of the services

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<sup>619</sup>Hogg, *Citizens, Consumers and the Nhs: Capturing Voices*. 3

previously managed by Regional Hospital Boards, such as boards of governors, Hospital Management Committees, executive councils and local health authorities. The second was to improve coordination between health authorities and local government. Finally, the reorganisation was aimed at improving management.<sup>620</sup>

Unfortunately, the new structure became the victim of attack from a number of political committees and plans issued by the political parties and the government.<sup>621</sup> The attack was directed at the inability to solve the previous problems. Moreover, the reorganisation caused delays in decision-making and there was a failure to establish good relationships between administrative tiers. Crucially, researchers stated that there was an increase in the cost of health services under the new structure – a structure which was supposed to reduce the cost of administration in health care provision.<sup>622</sup>

In 1976, these issues were analysed and reviewed by the Royal Commission on the NHS,<sup>623</sup> established at a time of substantial turbulence in the NHS. In its Report, the Commission concluded that the current structure included too many tiers of administration and too many administrators on each tier.<sup>624</sup> As a solution, the Commission recommended that there should be only one authority and one level in every region. Such a reorganisation aimed to reduce expenditure and also to clarify responsibilities.<sup>625</sup> This was followed by the enactment of the NHS Act 1977 which aimed to solve institutional problems within the organisation.

When the Conservative government took office in May 1979, it introduced its view about the reorganisation of the NHS in the *Patients First* proposals.<sup>626</sup> It was proposed that, to solve the structural dilemma of the NHS, one tier should be removed, as experts had suggested. However, instead of removing a tier, the government established a new body, the District Health Authority, to deal with all the functions of the existing areas and districts. Furthermore, in the *Patients First* consultation, the government recommended

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<sup>620</sup>Ham, *Health Policy in Britain*. 23

<sup>621</sup>Ibid. 23-28

<sup>622</sup>Klein, *The New Politics of the Nhs*. 62-66

<sup>623</sup>Ham, *Health Policy in Britain*. 26-27

<sup>624</sup>The Royal Commission on the NHS, "A Service for Patients," (HMSO, 1979). Para 22.71

<sup>625</sup>Ham, *Health Policy in Britain*. 23-24

<sup>626</sup>Department of Health and Social Security, *Patients First*, HMSO: London 1979.

that the Family Practitioner Committee be retained. The final plan for reorganisation was published in 1980. This strategy was largely based on the *Patients First* proposals.<sup>627</sup>

To improve health services, the Conservative government started dealing with the three main problems of the NHS: structure, management, and funding. In order to explain the government's perspective on these problems, it is important to analyse the two White Papers, *Working for Patients*<sup>628</sup> and *Promoting Better Health*.<sup>629</sup> In these papers, the Conservative government clarified its stance on the NHS and how it should be managed.<sup>630</sup>

In the first White Paper, the government focused on the redistribution of responsibilities and powers between the different tiers within the health service. It also dealt with the structure and management of the service. In relation to the issue of responsibilities and powers, the government worked to make doctors more responsible for their performance. The White Paper also emphasised the importance of the involvement of doctors and nurses in the management of the NHS – in both general practice and in hospitals – in a way that helped to improve cooperation between the two levels and to improve management of financial resources.

With regard to the structure of the NHS, the White Paper proposed some key changes to the delivery of health services, whilst remaining faithful to the basic principles of the NHS of free health care for all, paid for collectively by the taxpayer. Because the position of the government was built on a health system combining both public and private sectors, these changes were aimed at generating the preconditions for competition between purchasers and providers.<sup>631</sup> This period witnessed the birth of consumer rights in the UK health system as a result of the internal health market.<sup>632</sup>

Another important reorganisation of the NHS by the Conservatives was brought in from the top down, when the Prime Minister decided to establish an independent Department of Health, splitting the functions of the Department of Health and Social Security. The government also realised that more administrative independence was required at local and

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<sup>627</sup>Klein, *The New Politics of the Nhs*. 122, Charles Webster, *National Health Services Reorganisation: Learning from History* (London: Office of Health Economic, 1998). 20

<sup>628</sup>"*Working for Patients*," (London: H M S O, 1989).

<sup>629</sup>"*Promoting Better Health*," ed. Secretaries of State for Social Services (London: HMSO, 1987).

<sup>630</sup>I. Crinson, *Health Policy: A Critical Perspective* (Sage Publications Ltd, 2009). 65, and Ham, *Health Policy in Britain*.37-39

<sup>631</sup>J. Le Grand, "Competition, Cooperation, or Control? Tales from the British National Health Service," *Health Affairs* 18, no. 3 (1999).

<sup>632</sup> See S. Pickard and K. Smith, "A 'Third Way' for Lay Involvement: What Evidence So Far?," *Health Expectations* 4, no. 3 (2001).

regional levels. Thus, the District Health Authorities (DHAs) were given the job of allocating the budget for health care. The DHAs administered hospital and community health services and were allowed to use private contractors; this led to the separation of the responsibility for purchasing and providing the service, intended to give patients 'rights to choice' and create competition in the internal market. To achieve this separation of responsibility, new bodies – self-governing NHS trusts - were created to manage services, thus allowing the DHAs to concentrate on purchasing health care for the citizens of their areas.<sup>633</sup>

In the second White Paper, *Promoting Better Health*, the government aimed to achieve two goals. Firstly, it aimed to offer a better health service and greater choices to patients. Secondly, the government used financial incentives to encourage general practitioners to respond positively and efficiently to local need and to promote competition between the providers of family practitioner services.<sup>634</sup> The Conservative government was criticised for its competition policy and the changes it made to the internal health market due to the associated increase in public spending, especially since researchers have shown that public expenditure increased due to changes in the management of the NHS without making improvements to the health services.<sup>635</sup> In relation to health care as legal right, it is important to note that these proposals gave the patient a right to choose.

To summarise, the government may have succeeded in giving the patient better choices in health care by allowing health insurance companies to work in the internal market, or by encouraging general practitioners to improve their service at the local level. However, it appears that from 1974-1996 the provision of health care services in the UK was treated not as a public good but as a market. Nevertheless, in principle, and as a result of the NHS Act of 1977, such services were still treated as a legal right. However, the state incurred great costs. For political and ideological reasons, the Thatcher government tried to design a health policy which was closer to the USA's health system. One can say that health care at that time was treated as a 'legal right' but not a 'human right'. Thus, in the public hospitals, for example, patients accepted what they were offered and followed the choice that was made by the doctors or used the health market to obtain what they wanted.

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<sup>633</sup>Crinson, *Health Policy: A Critical Perspective*. 65

<sup>634</sup>D. Hughes, "General Practitioners and the New Contract: Promoting Better Health through Financial Incentives," *Health policy* 25, no. 1-2 (1993). 40 Crinson, *Health Policy: A Critical Perspective*. 66-67

<sup>635</sup>Ham, *Health Policy in Britain*. 45-46 and Crinson, *Health Policy: A Critical Perspective*. 65-66 see also Fitzpatrick, Surender, and Chandola, "Health and Health Care." 336

The notion of the patient as a consumer started to develop and his or her voice become louder; thus the government focused on giving patients increased health care choices and more space for positive participation. Thus, some rights attached to health care developed, such as the right to information which means that patients should be aware of their health status and the risks posed by suggested treatments. The right to primary health care also became familiar.

In 1974 the establishment of the CHCs gave the public a practical opportunity to share in the making of decisions relating to health care and also in the monitoring of how the health authority treated patients' needs in their region. The concept of rights, or the language of rights, was also becoming frequently used to describe the relationship between patients and health providers. The best example of this matter is the issuing of the Patient's Charter by the NHS in 1991.

### **4.2.3 Health Policy Focuses on Patients' Rights**

In 1997 the NHS returned to quieter times following the election of the Labour government led by Tony Blair. The new government introduced new proposals which were known as the 'Third Way' of reform. In the Third Way, the Labour Party leader attempted to formulate distinct views to counter both old left and new right views by combining planning and competition, centralisation and local independence, rights and responsibilities and, finally, a wide partnership including public and private sectors as well as civil society.<sup>636</sup>

The Labour party presented new health care policies under the Blair government that drew on the advantages of the Thatcher government reforms, such as the separation of providers and purchasers.<sup>637</sup> To improve the quality of health standards, the separation was important to clarify the responsibilities and duties of all health care service bodies.<sup>638</sup> Under the Labour health reform of 1997, the government attempted to focus on 'patient choice' and deal with the patient as a consumer. This did not make a real change to the previous government's position but, from a legal perspective, such movements underpinned the concept of a 'legal right', in some ways indicating the existence of a concept of human rights in health care matters.

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<sup>636</sup>C. Ham, "The Third Way in Health Care Reform: Does the Emperor Have Any Clothes?," *Journal of Health Services Research & Policy* 4, no. 3 (1999).

<sup>637</sup>Ham, *Health Policy in Britain*. 51-52, see also J. Lister, *The Nhs after 60: For Patients or Profits?* (Middlesex University Press, 2008). 117-121 and D. J. Hunter, *The Health Debate* (Policy Press, 2008). 96

<sup>638</sup>Fitzpatrick, Surender, and Chandola, "Health and Health Care." 339

In December 1997 and based on its 'Third Way' proposals, the Blair government developed a new policy which showed its perspective on the NHS. The new policy contained six main principles that were behind the governmental health strategy published in its White Paper, *The New NHS*.<sup>639</sup> To some extent, it seems that using the concept of partnership within the NHS operation was a concession towards the WHO suggestions in the Declaration of Alma Ata as explained in the second chapter of this thesis.<sup>640</sup> Later, the Labour government took the patient's choice into account; as a result, that choice became the cornerstone of the government white paper.<sup>641</sup>

In general, it appears that the new government had, from a different perspective, recognised that the proposed changes in the NHS should not only focus on its structure and how expenditure could be reduced, but instead that more attention should be paid to the quality of health care and how to improve its provision in both quantity and quality. Such a focus would, no doubt, reflect on patient recovery, the level of health expenditure and the delivery of health services.<sup>642</sup>

To ensure the improvement of the health service and promote the rationality and efficiency of its financial allocations, the National Institute for Health and Clinical Excellence (NICE) was created as an independent organisation in 1999. NICE is responsible for offering guidance in three areas of health, such as the prevention of illnesses and the promotion of health in society including for those who work in the health sector. Further guidelines on health technologies aim to clarify whether new or existing medicine should be used in the NHS, while clinical practice guidelines deal with why particular treatments should be employed by the NHS in caring for patients with specific diseases and conditions.<sup>643</sup>

In addition, the *New NHS*<sup>644</sup> proposal succeeded in highlighting the importance of the partnership concept in the NHS, which aimed to persuade all those involved, including NHS staff, to realise that health responsibilities are not only a governmental duty but that all members of the society are responsible for their own health as well. As such, the

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<sup>639</sup>Secretary of State for Health, "The New NHS Modern, Dependable" (London: HMSO, 1997).

<sup>640</sup> See for example Green, Ross, and Mirzoev, "Primary Health Care and England: The Coming of Age of Alma Ata?."

<sup>641</sup>K. Morrell, "Policy as Narrative: New Labour's Reform of the National Health Service," *Public Administration* 84, no. 2 (2006).

<sup>642</sup>Ham, *Health Policy in Britain*. 53 and Crinson, *Health Policy: A Critical Perspective*. 67-69

<sup>643</sup>The NHS, <http://www.nice.org.uk/aboutnice/>

<sup>644</sup> Secretary of State for Health, the New NHS, Modern, Dependable, the Stationery Office

achievement of any success in this field will always rely on the cooperation of all participants, including the patient. Such cooperation requires minimising health expenditure and rebuilding public confidence in the NHS.

As a result of these proposals, new health bodies, such as NICE, were established to share responsibility with the NHS. By contrast, one can say that the Libyan health system needs to create a partnership which will help to restore public confidence. According to the WHO report about the health system in Libya, Libyan citizens prefer to access health care services outside their country. The same report shows that more than 20% of the health budget was spent on treatment abroad instead of improving the status of health care in the country.<sup>645</sup> This is evidenced by the fact that in all of the cases concerning health care brought to the courts by Libyan citizens, analysed in the previous chapter, applicants were asking to travel overseas to access health services; none of them raised the need for improvements in the provision of health care in Libya. This is because they did not trust the health authorities and because of concerns about the standard of care they might receive.<sup>646</sup>

Returning to the *New NHS* in the UK, the focus on the quality of health care by the Labour government did not mean that they ignored the structural problems within the NHS. As with previous UK governments, the Labour government proposed that the NHS structure should be changed in a way that assisted in achieving the proposals' objectives, such as forming partnerships and rebuilding public confidence in the NHS. For these reasons, the government changed the structure of the NHS from centralisation towards decentralisation, giving the local health authorities the ability to take quick and appropriate decisions in accordance with NICE guidelines. The decentralisation of health care was an important move, given that by its very nature, particularly in serious case, a rapid reaction from the health authorities will be needed. Such decision-making is more difficult, if not impossible, under a centralised system of health care.<sup>647</sup>

Although health care services improved over this period of time; for example, the waiting-list times, as the reports<sup>648</sup> show, were reduced and patient care in the NHS was improved,

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<sup>645</sup> "Libya" in *EMRO Health System Profile* (Cairo: Regional Office for the Eastern Mediterranean, 2007). 48

<sup>646</sup>In all health care cases that were reviewed by Libyan courts, claimants demanded to be treated overseas rather than requiring the improvement of health services in the country, as already indicated in previous chapter.

<sup>647</sup>Ham, *Health Policy in Britain*. 53-55

<sup>648</sup>J. Appleby, *Sustaining Reductions in Waiting Times: Identifying Successful Strategies: Final Report to the Department of Health July 2004* (King's Fund, 2005).

there was, nonetheless, criticism of Labour health policy. Despite the fact that the NHS saw considerable development since the Labour government was elected in 1997<sup>649</sup> the new government has a lot of work that needs to be done to reduce waiting time, especially given the influence of European Union health policy on Member States and the increasing role of the courts in the field of health care, as will be explained in the coming sections. In 2000, the NHS took further steps towards the clarification of citizens' health care rights by adopting the *NHS Constitution*<sup>650</sup>, which aimed to clarify the rights of the patient and the duties of the providers of health care services. It should be noted that such a constitution does not exist in the Libyan health care system.

To conclude, this brief analysis has shown that health care in the UK is still treated as a legal duty of the state rather than a human right, while there are several indications which show that it is legally protected and can be identified under the English legal system. The first indication is the NHS Act, under which the state became responsible for the provision of health care to all its citizens. Such an enactment gave individuals a legal right to access health care. The second indication is the wider interpretation of European Convention rights, as will be explained below, that has been adopted by the courts, both domestically and regionally, to protect the right to health care even though this was usually in extremely exceptional circumstances. The third indication is the case law of English courts which no longer accepts that health care is solely a matter for government.

In fact, health policy in the UK has seen many changes and developments since the creation of the NHS. These changes and developments were designed to re-evaluate the structure and policies of the NHS, to improve service delivery to the public, to improve the quality of the service and to reduce its cost. In this context, it is important to note that the government had created a special body to make and review these policies within the NHS and this can be seen as a key element in the improvement of the health care services in the country. Thus, the question is not about the legal status of the health service but about what it should include and how it can be delivered versus the expectations of the citizen who is suffering illness in the age of advanced technologies and everyday progress in the biomedical industry.

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<sup>649</sup>J. Appelby, "Cutting Nhs Waiting Times: Identifying Strategies for Sustainable Reductions," *King's Fund Publications* (2005).

<sup>650</sup>Department of Health, *The NHS Constitution*, London, Department of Health, 2012 available at [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_132958.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132958.pdf) accessed 02/10/2012

Thus, one can see that there has been a progressive change in the nature of the provision of a health service from merely a ‘social aid’<sup>651</sup> to a ‘legal duty’ and then to a ‘legal right’ but yet it is not a ‘legal human right’. The important of this change in the status of health services is to show that there is responsibility on the state to offer these services. The concept of health care has also been given special consideration in exceptional situations, as will be seen in some of the judicial review cases. Therefore, the importance of the National Health Service Act lies not only in the fact that the health service was to be financed by tax revenues, but also in its clarification that the free health service was no longer to be provided only to the poor or vulnerable groups in society.<sup>652</sup> In fact, since 1948, health care has been based on a sense of solidarity where all members of the community can share in the cost of the service that is provided to all social classes.<sup>653</sup>

The original principles of the NHS were to provide health care services to all citizens of the UK free of charge at the point of need. Nonetheless, some policies have made some attempt to adopt an open market policy, or to place restrictions on the rights of non-resident migrants to access health services, even to the extent of imposing fees on visitors to the UK when they require health services.<sup>654</sup>

It is also important, before going on to the next section, to clarify that the legal development of health care in England has been, to some extent, influenced by the European Union as will be seen in the section dedicated to this matter. But now there will be a discussion as to what the right to health care means in English legal system and whether there are common characteristics that exist in both such a concept and in the proposed definition in this thesis.

## **4.3 The Concept of the Right to Health Care in the UK**

### **4.3.1 Introduction**

With regard to the concept of the right to health care in the UK, there are a number of materials that can be utilised to enable one to get an idea of the concept. These materials include the constitution, legislation, case law, parliamentary documents, academic writing

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<sup>651</sup>Porter, *Health, Civilization, and the State: A History of Public Health from Ancient to Modern Times*. 145

<sup>652</sup>M. Rintala, *Creating the National Health Service: Aneurin Bevan and the Medical Lords* (Routledge, 2003). 14-30, and Baggott, *Health and Health Care in Britain*. 88-89

<sup>653</sup>A. Talbot-Smith et al., *The New Nhs: A Guide* (Psychology Press, 2006). 3

<sup>654</sup>T. Yates, R. Crane, and A. Burnett, "Rights and the Reality of Healthcare Charging in the United Kingdom," *Medicine, Conflict and Survival* 23, no. 4 (2007). 297-304

and international agreements. One useful source, for instance, is the National Health Acts themselves. According to the National Health Services Act 1977

*(1) It is the Secretary of State's duty to continue the promotion in England and Wales of a comprehensive health service designed to secure improvement—(a) in the physical and mental health of the people of those countries, and (b) in the prevention, diagnosis and treatment of illness, and for that purpose to provide or secure the effective provision of services in accordance with this Act. (2) The services so provided shall be free of charge except in so far as the making and recovery of charges is expressly provided for by or under any enactment, whenever passed.*<sup>655</sup>

The Act also sets out the general powers of the Secretary of State and how services in general should be provided. From this part of the Act, two observations can be made. The first is that the concept of health care services in the UK is, for the most part, the same as in Libyan health legislation. The second is that UK legislators focused on the idea of the right to health *care* rather than a right to *health*, as sometimes appears in international instruments.

By contrast with the proposed definition of the right to health care, the NHS Act includes environmental issues and food services in connection with hospital accommodation. These can be understood as an essential component of the provision of in-patient services to heal ill people. Another important feature is the differentiation in responsibility between the health care obligations of the Secretary of State for Health, and environmental matters, which are the remit of the Department of Environment, Food and Rural Affairs (Defra): the latter are explicitly outside the concept of health care despite their potential to impact on health.

In this context, Hervey's view is likely to be correct when she stated that "exploring the implication of realizing a 'right to health' in the context of the English legal system, identifies a four-fold typology of obligations: protection from disease and accidents; protection from adverse environmental factors; promotion of a healthy environment and provision of health care services."<sup>656</sup> These elements of health care appear to be affected by the international notion of the right to health. It is important to note that Hervey means the right to 'health care' even though she used the term 'right to health'. The second source of what the right to health care means in the UK is case law. It can assist in the clarification of the concept and the scope of the right. As will be explained, case law can

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<sup>655</sup>National Health Services of 1977

<sup>656</sup>Hervey, "The "Right to Health" in European Union Law." 201

also show how an applicant builds his/her claim and what health care means to him/her. From this perspective, one can say that, in the view of the patient or the applicant, health care means protection from diseases and attaining curative health care programmes, which of course include offering essential medication, hospital services and providing services with qualified medical staff, if necessary. This view of health care is similar anywhere in the world.

The situation in the UK is completely different from that in Libya. In the UK, courts have shed more light on the legal aspects of health care, accepting that a patient may not simply accept what health authorities provide without argument merely because organisations do their best for the health of citizens in the light of the resources available. As a result, UK courts, as will be seen, have succeeded in striking a balance between the rights of the patient, the powers of the health authorities and the scarcity of financial resources. By using their interpretive power, they have been able to intervene in how and where the government spends its financial resources for health care.

#### **4.3.2 The Legal Features of the Right to Health Care in the UK**

From the above discussion, it is clear that the right to health care is the concept that the Department of Health endeavours to ensure is offered free of charge at the point of delivery. This right has four main constituents: the provision of hospital accommodation, a preventative health programme, a curative health programme including health care services and ambulance services, and the supply of essential drugs.

These elements of the right to health care present the essence of the responsibilities of the health department as required by both national and international law. Such services should be provided to all citizens irrespective of their gender, colour, religion, financial ability or ethnic background. The providers of these services are also legally obliged to work towards the best interests of the patient, taking into account their health conditions, the degree of pain and medical history.<sup>657</sup>

The main legal standing and content of the right to health care can be identified from case law in both national and international courts.<sup>658</sup> In the last three decades, cases based on the right to health care have increasingly been brought before the courts for resolution and

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<sup>657</sup>C. Newdick, "Who Should We Treat?: Rights, Rationing, and Resources in the Nhs," *OUP Catalogue* (2005). 243

<sup>658</sup>For examples see A. Hendriks, "Right to Health in National and International Jurisprudence," *Eur. J. Health L.* 5(1998).and G. Davies, "The Effect of Mrs Watts Trip to France on the National Health Service," *King's Law Journal* 18, no. 1 (2007). Also cases such as *R versus Cambridge Health Authority Ex parte B*, 25 BMLR 129(1995 ).and *N versus United Kingdom* 25 BHRC 258(2008).

clarification. Therefore, the courts have played a fundamental role in developing its status as a legal right and have begun to set out the necessary legal reasoning that would justify intervention in an area which had hitherto been treated as a political issue rather than a judicial matter.

The increasing drive towards judicial recognition of the right to health care is important. First, the intervention of the courts can give a definitive answer to the question whether the right to health care is a justiciable right and thus a legal right. Thus, it can be seen in cases that a judgement has played a real role in changing national health policy and can influence the understanding of policy-makers themselves. For instance, the courts, such as the ECJ, were behind the establishment of the “undue delay principle”<sup>659</sup>. This principle is now used to determine whether a patient should be allowed to obtain treatment abroad and ask for reimbursement or whether the national health authority of their own country is capable of meeting their health care needs in a time and manner appropriate to their condition. Secondly, and most importantly, in such cases, the court always justifies its decision by creating a workable concept that can reflect on the concepts of justice and fairness for both parties. Thirdly, and as a result of the previous two reasons, the jurisprudence of the courts in relation to the right to health care will highlight its legal roots and explain its nature as a legal right. Therefore, in general, one can conclude that the courts, whether national or international, are often the main measure of public policies and laws, evaluating their logic, rationale and the possibility of their implementation. This role can be seen clearly in the judgments of the courts, especially those of the European Court of Justice at the European level.

By contrast, although the Libyan concept of the right to health care is similar to that in the UK, at least theoretically, the courts have not dealt with the issue as seriously as has been the case in the UK. In most, if not all, of the cases involving the right to health care, especially those that had been reviewed by the Libyan Supreme Court, the courts dismissed the cases without acceptable reasons. In the UK, the courts have stressed that a lack of resources is not a sufficient justification to stop providing treatment to certain patients; nevertheless, the Libyan courts, including the Supreme Court, still rely on the availability of financial resources to decide whether or not the health authorities are responsible.

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<sup>659</sup> Case C-372/04 *Yvonne Watts versus Bedford Primary Care Trust, Secretary of State for Health* [2006] ECR I-4325 and Davies, "The Effect of Mrs Watts Trip to France on the National Health Service."

To sum up, it is clear that the concept of the right to health care in the UK legal system appears to be much clearer than in Libya. Thus, there is sufficient evidence that the three characteristics of the right to health care, as explained in this thesis, exist in the UK. In addition, the features of this right developed gradually based on the outcome of case law. In other words, the concept of the right to health care has become workable. Finally, case law has performed an important function in determining the scope of the right to health care and social rights in general. As an independent body the court is able, and qualified, to draw a justifiable balance between the interests of the citizen and the community. It can promote change and contribute positively and effectively in developing a culture of rights in society and it can persuade other public authorities to respect human rights including its own human rights' judgments.

In regard to the right to health care in the UK, one may argue that these services are similar to those provided by the national health services in Libya in terms of being delivered free of charge and financed by the public budget. In the UK, however, it seems that the health authorities were able to build a health care system which could meet the health requirements of the population and deal with serious health cases. This has the benefit of modern and effective medical technology, although the growing demand on these services is often affected by the availability of financial resources. It is important to note that the British health authorities have successfully innovated new methods and initiatives, such as the NICE, GPs' financial budgets and promoting the private health sector, in order to rationalise the expenditure on health services.<sup>660</sup>

In the British legal system national courts are still the main point for adjudicating on the decisions of public authorities, including NHS bodies. Therefore, they can succeed in protecting patients' rights by using their traditional judicial review power, even if no such specific right exists in the HRA 1998.

In the previous chapter, as has been shown, the situation was different in Libya. The Libyan authorities are not restricted by international institutions or African bodies even though these authorities have signed and ratified most of the international and regional human rights treaties - the African Court of Human Rights, for instance, has not yet dealt with any case. In fact, the African Court exists on paper but not in reality. Thus, if they are to take this matter seriously, the national authorities, including the courts, in Libya need to rely on themselves to create a clear human rights' system. Because of their significant

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<sup>660</sup>A good example of these methods is NICE, as will be discussed in the coming sections of this study

impact on the UK human rights' system, international health obligations will now be discussed and then the national health care obligations and case law will be explained.

## **4.4 Justiciability of the Right to Health Care in the UK**

It might seem that, theoretically, health care can be assumed to be a human right and also that, by reference to international human rights law, the right to health care, as explained in this thesis, means the state has a responsibility to provide health care services for all citizens, at least under Article 12 of the International Covenant of Economic, Social and Cultural Rights. But in practical terms, there are still difficulties in treating health care as a full human right, as has already been seen.

With this in mind, this section will try to show when the right to health care can be considered judicially as a legal right or a human right. To do so, it is important to discuss how the right to health care is protected in the UK, especially by the public authorities, Parliament, and courts. As a public service provided by the state, health care needs the support of all these state authorities which may result in tensions between them. Thus, it is helpful to discuss the power of these authorities and how health care is protected in light of this power.

### **4.4.1 The Right to Health Care: the Relationship of Parliament, Executive and the Courts**

According to UK constitutional law, fundamental freedoms and rights can be protected by Act of Parliament. In the light of the supremacy of Parliament, as will be explained in the following parts of this discussion, changing a constitutional norm could be achieved through the ordinary process of statute enacted by the national Parliament. Thus, Parliament has the authority to curtail or diminish rights that in other countries are considered as fundamental rights. It appears that in the UK legal system there is no hierarchy of laws and, therefore, that all parts of law have the same value.<sup>661</sup>

Under this position, an Act of Parliament is not subject to judicial review. This primary characteristic of the UK constitution has been protected in sections 3(2) and 6(2) of the HRA. For this reason, the power of the courts to review Acts of Parliament is restricted. The courts can only determine whether an Act is compatible with the HRA or the European Convention or not. From a traditional perspective, the judicial review judge must apply the

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<sup>661</sup>H Fenwick and G Phillipson, *Text, Cases & Materials on Public Law & Human Rights*, 2 ed. (London: Govendish Publishing Limited, 2003).

Act even if it places limitations on the right in question. As such, Parliament has started to take into account the European Convention provisions before adopting new legislation. Thus, according to article 10 of the Convention, judges are able to interpret any vague domestic provision of an Act that appears in conflict with the European Convention. Building on this observation, EU law, as will be explained below, has also limited the sovereignty of the Acts of Parliament. This is emphasised by the ECJ.<sup>662</sup> The supremacy of Parliament is no longer absolute.

It is important to note several points here which can assist in understanding how, and to what extent, various rights have been protected in the UK legal system. Firstly, the UK, as a western country, has focused on political and civil rights rather than economic and social rights; As a result, domestic courts did not consider health care as a human right. The powers of courts were limited to judging the actions of medical professionals and whether they had reasonably fulfilled their professional medical roles with due care and responsibility.

Secondly, the nature of UK constitutional law, which is based on an unwritten constitution, makes rights looked residual rather than entrenched. But this, according to Dicey,<sup>663</sup> should not be seen as a weakness. The absence of a written constitution or bill of rights in the UK is a source of strength which allows citizens to have more space for freedom than those who are restricted by specific words included in a constitution or bill. Such a view was adopted in *Derbyshire County Council v Times Newspapers*<sup>664</sup> where the House of Lords dismissed the appeal because they concluded that there was no difference in respect of freedom of speech between the common law of England and Article 10 of the Convention. In contrast to this, there are writers who support the idea of a written bill of rights which would protect people from politicians' opinions.<sup>665</sup> They consider judges as an unelected authority so they are not empowered to determine what rights people can exercise and how, nor to intervene in the duty of elected bodies such as the executive and Parliament.<sup>666</sup> In

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<sup>662</sup>D.W. Vick, "Human Rights Act and the British Constitution, The," *Tex. Int'l LJ* 37(2002). 370

<sup>663</sup>AV Dicey, "The Law Ofthe Constitution," (London, 1885). 39-40

<sup>664</sup>[1992] QB 770.

<sup>665</sup>J. Wadham, H. Mountfield, and C. Gallagher, *Blackstone's Guide to the Human Rights Act 1998* (Oxford Univ Pr, 2009). 5, I. Leigh and R. Masterman, *Making Rights Real: The Human Rights Act in Its First Decade* (Hart Pub., 2008). 13

<sup>666</sup>J. Wadham, Mountfield, and Gallagher, *Blackstone's Guide to the Human Rights Act 1998*.5, Palmer, *Judicial Review, Socio-Economic Rights and the Human Rights Act (Human Rights Law in Perspective)*. 26-27

fact, many commentators still believe that the HRA, to date, has made no change to judicial power to review governmental decisions.

In the light of these two points, the question of whether health care is a legal right should be raised here; and if so, what powers the courts have to review the decisions of health authorities. Firstly, there is no statute in Britain in which health care is categorised as a human right, including the HRA. Secondly, the UK courts have never regarded health care as a human right. In the pre-HRA era, the judiciary illustrated a general commitment to develop common law with the basic object of preventing the application of arbitrary power. In other words, the judges would not involve themselves in adjudicating a decision of a Minister or an Act of Parliament if it appeared that the Minister had respected all required procedures and had used his powers correctly, as directed by the law, and based on clear legal reasoning. If this is the case, the decision must be implemented regardless of its hidden negative effect on human rights. Courts were unwilling to interfere in health decisions which were included within the jurisdiction of the health authorities of the state. National courts also recognised local circumstances that might influence the decisions of the health bodies.

Bearing this in mind, the courts began to judge decisions made by the health authorities reluctantly through the traditional principles of judicial review, which allow the courts to quash decisions based on grounds such as irrationality, illegality or where there have been serious procedural irregularities.<sup>667</sup> Thus, review focused on the duty to provide access to health care rather than as a human right to health care. In this context, it is important to note that, although there is no clear concept of a right to health care in domestic judicial reviews, individuals are entitled to challenge any decision that might obstruct their opportunity to gain treatment provided or funded by the NHS because of their exceptional circumstances which deserve to be taken into account.

In the following discussion, attention will be paid as to how the courts dealt with decided judicial reviews relating to the delivery of health care in the UK. As indicated elsewhere, the judicial reviews identified with negligence will not be included.<sup>668</sup> Instead, the focus will be on the question of the legitimacy of claims concerning rights in health care and how the courts have treated these claims. In order to explain how these decisions have

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<sup>667</sup> *Associated Provincial Picture Houses Ltd versus Wednesbury Corp* [1947] 1 All E.R. 498

<sup>668</sup> R. Palmer and M.C. Maclachlan, "Clinical Negligence," *Anaesthesia & Intensive Care Medicine* 13, no. 4 (2012); M. Khan, *Clinical Negligence* 2ed. (Routledge Cavendish, 2001). J.V. McHale, M. Fox, and J. Murphy, *Health Care Law: Text and Materials* (Sweet & Maxwell, 2007). 149-288

developed and what influence they have had on the provision of health care in the UK, this section will consider each case individually to show the lessons that can be learned from them in terms of the right to health care.

In general, decisions of health authorities can be challenged in court when one of the following situations applies:

1. When health authorities refuse to provide health services.
2. When they provide services that are considered to be lower than the standard that the patient expected.
3. When health providers refuse to offer a certain service that is demanded by the patient but from the viewpoint of the authority such a service is not necessary for his or her health

Cases occur, broadly speaking, when there is a denial of the patient's right to access the services they want. But before dealing with judicial review cases, it might be important to explore how writers look at judicial reviews and what the judiciary is empowered to do, in particular where the State is involved.

The extent to which the judiciary can intervene in the shaping of public policy is arguable. It is well known that the judiciary is one of the three arms of the state's power that is shared with Parliament and the government in light of the principle of 'the separation of powers'.<sup>669</sup> The main function of the judiciary is to resolve conflicts in society by implementing the law and interpreting it in a way that helps to realise justice. Sometimes, and with the aim not to deny justice, the judiciary can create legal precedents where there are no pre-existing legal rules that can be implemented in the case in question.<sup>670</sup>

In general, this is welcomed by jurists and political writers where the case parties are individuals but not where one of the parties is the government, which is in a similar position to parliament and the judiciary. Some decisions, especially when the decisions of the government have been quashed, have raised a number of questions and arguments about who controls the state and the extent to which an unelected body can intervene in

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<sup>669</sup>P. O'Connell, *Vindicating Socio-Economic Rights: International Standards and Comparative Experiences* (Routledge, 2012). 169-172

<sup>670</sup> In common law judges usually authorised to solve the dispute in question so when there is no legal rule (custom, legislation or any other sort of legal rule) can be applicable on the case, judges can create a new principle to solve the problem in respect to justice and rationality but this is often be a informal source of law. In Libya, for example, article 1 of the Civil Code includes this source in its second part under so-called Ajthad. See about the role of the judges in making law E. Bell, "Reflecting on the Judicial Role: How Valid Is the Analogy That 'Judges Are Like Umpires'?", *Commonwealth Law Bulletin* 38, no. 1 (2012).

issues that are assumed to be the jurisdiction of an elected body. Of course, this is not the subject of this thesis. But it might be significant to note that the judiciary itself has recognised this fact, so that judges tend not to get involved in political issues or public policy unless the decision was clearly irrational or illegal.<sup>671</sup>

In the English legal system, non-intervention of the judiciary in issues that relate to government or Parliament appears to be well established. Thus, judges are empowered only to decide whether there is incompatibility with legislation in the action or policy in question and leave the final decision of how to deal with such a situation to the government or Parliament. Therefore, at least in the view of this thesis, judges are aware of their powers and have generally acted with logic and in an appropriate way to preserve the balance between the three wings of the powers of the state. Courts understand that health is a domestic affair controlled by government, which has a margin of discretion in such matters, including in the allocation of limited health resources.

With this in mind, it is important to clarify that although the judiciary is important; its role is limited in what it can achieve because the actual provision of the services depends on the Executive. The Executive has the ultimate right to decide what discretion is devolved to Ministers, what budget is allocated to the Minister and so on. As will be explained in the cases discussed below, this can encourage one to say that the UK situation is good, but not perfect. Nonetheless, the judiciary has the right to scrutinise governmental decision-making in terms of its rationality, legality, reasonableness and proportionality. Thus, in health care cases, for instance, courts have a supervisory jurisdiction over governmental bodies such as the Ministry of Health or the NHS but they are not the health provider. In other words, the function of the courts is to ensure that the decisions made by governmental authorities conform to the law and that standards of fair procedures are respected.<sup>672</sup>

In exercising this jurisdiction, it is important to emphasise that the legal principles of judicial review should not be haphazard, incoherent or contradictory. In addition, judicial review often gives rise to political controversy such as when courts reassess decisions related to health policy or other public policies. In such a case, it is significant that the

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<sup>671</sup>Ewing K. D Bradley A W, *Constitutional and Administrative Law*, 5 ed. (Pearson, 2011). 669-82; E Jackson, *Medical Law, Text, Cases, and Materials*, 2 ed. (Oxford University Press, 2010). 77-86

<sup>672</sup>Peter Leyland and Gordon Anthony, *Text Book on Administrative Law*, 7<sup>th</sup> ed, Oxford University Press, 2013, 184

judges should base their judgment only on legal grounds. Another important point needs to be highlighted; namely, that judicial review is procedurally limited to administrative action that is controlled by public law. Therefore, if the public authority's action was taken under the terms of a contract or when it was acting as a private person, judicial review may not be used. Moreover, judicial review of public authorities' actions can also be limited by time. This means that the applicant must raise the action within a specific period of time - duration three months in the UK<sup>673</sup> (In Libyan law, the time limit is 60 days from becoming fully aware of the administrative decision). Consequently, if s/he does not submit her or his objection to this decision during this period s/he would not be able to bring the case to court. The previous point may not, of course, be applicable if the case was related to human rights or public order which ought to be protected even after the passing of time.

It is also worthy of note that the role of judicial review, while important, cannot answer all questions. It is for the Executive and the legislature to put in place the resources to supply what people arguably need. At present, the system means that restrictions can be placed on access to health care, based on decisions taken at Executive level and which cannot be overturned by means of judicial review. While this is not a bad model for countries such as Libya, arguably it does not go far enough in human rights terms. The limitations of judicial review are clear – constrained by the test to be adopted, as discussed above.

In short, there are limits to the use of judicial review which can be briefly stated as follows: there is no right to judicial review. Therefore the claimant must request the court for permission to raise the action. The claimant must proceed within a very restrictive three month time limit; there must be a sufficient interest for the claimant to pursue judicial review, the courts have discretion in remedies, so even if the decision was unlawful they do not need to overturn it if there are good reasons for giving it effect, the judicial review is a last resort so permission for judicial review would not be granted when there is another adequate method that can be used by the claimant for the appropriate remedy, finally, in the case of an unlawful decision, judges have wide power to send the issue back to initial decision maker to rectify the situation. Therefore, judicial review, as pointed out by McHale and Fox, constitutes a review of a decision rather than an appeal with the prospect of the decision being overturned but then remitted to the original decision maker to redetermine it.<sup>674</sup>

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<sup>673</sup> Timothy Endicott, 2011, *Administrative law*, 2nd edition, Oxford University Press, 63

<sup>674</sup> Jean McHale, *Law, Patient's Rights and NHS Resources Allocation: Is Eurostar the Answer?*, *Health Care Anal*, 2006, 14, 17

English courts have been reluctant to involve themselves in social and economic issues, in particular in health affairs, which are usually held to be under the jurisdiction of the executive body. In light of the above, the courts have, in several cases, refused to find against the Minister of Health (or other government bodies) when he had done his best within the available resources set by Parliament.

In the case of *R. v Secretary of State for Social Services Ex p. Hincks*,<sup>675</sup> the Court of Appeal rejected the patient's claim that postponing plans to expand a hospital in Staffordshire with the aim of improving facilities for orthopaedic surgery in the local area was in breach of the Secretary of State for Health's duties in section.3 of the 1977 Act.<sup>676</sup> In response, the Ministry of Health argued that the Secretary of State and his Ministry had done everything possible, including planning, to improve the service in the hospital in question, but that the money awarded by Parliament was not enough to implement this plan. As a result, the plans for improvements were cancelled. The court clarified that the Secretary of State for Health has a duty, as explained in Section 3(1) of the National Health Service Act 1977, to improve hospital accommodation, medical, dental, nursing and ambulance services etc. Fulfilment of this duty, however, depended on the budget devoted to this by Parliament, which is not under control of the Ministry of Health. As a result, the court found that there was no responsibility.

In its judgment, the court indicated that:

“It cannot be that the Secretary of State has a duty to provide everything that is asked for in the changed circumstances which have come about. That includes the numerous pills that people take nowadays: it cannot be said that he has to provide all these free for everybody”.<sup>677</sup>

In the case of *R v Central Birmingham Health Authority, ex parte Walker*<sup>678</sup>, the parents of a child in need of heart surgery were told that the surgery would not take place on the expected date because there were no qualified nurses available to look after him. Thus, they sought leave for judicial review against the health authority. The authority accepted their contention but argued that such a subject was not a matter for judicial review. The court agreed with the authority's view and refused to grant leave for a judicial review and agreed not to examine the case. The court clearly stated that “... It is not for this court, or

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<sup>675</sup>(1979) 123 S.J. 436

<sup>676</sup> National Health Services Act of 1977, on line at <http://www.legislation.gov.uk/ukpga/1977/49> accessed 11/07/2012

<sup>677</sup>R versus Secretary of State for Social Services, West Midlands Regional Health Authority and Birmingham Area Health Authority (Teaching), ex parte Hincks and others [1980] 1 BMLR 93

<sup>678</sup> R versus Central Birmingham Health Authority, ex parte Walker 3 BMLR 32

indeed any court, to substitute its own judgment for the judgment of those who are responsible for the allocation of resources”.<sup>679</sup> The judge went on to state that:

“This court could only intervene where it was satisfied that there was a prima facie case, not only of failing to allocate resources in the way in which others would think that resources should be allocated, but of a failure to allocate resources to an extent which was *Wednesbury* unreasonable.”<sup>680</sup>

In another example, however, the court was ready to quash decisions about resource allocation. In *R. v Gloucester CC, Ex p. Barry*; *R. v Lancashire CC, Ex p. RADAR*,<sup>681</sup> the Court of Appeal indicated that Gloucester County Council (CC) should pay special attention to the specific needs of clients and not only just to expenditure. Reducing expenditure by withdrawing services from a class of persons or a category of illness means that the authority failed to meet its existing duties under section.2 of the Chronically Sick and Disabled Persons Act 1970. Here, it is important to note that the court distinguished between the duties of the authority under the above Act and those under the NHS Act, where resources are still a relevant concern.

In other cases, such as *R. v North East Devon Health Authority, ex parte Coughlan*,<sup>682</sup> the court stressed that the patient had a legitimate expectation, based on the promise included in the Chronically Sick and Disabled Persons Act 1970 and the NHS Act, as a matter of practical policy. Thus, the Court of Appeal, in this case, struck down the authority’s decision to close Madron House where Coughlan and others had been living since 1993 following the closure of the hospital at which she previously resided. The court based its decision on the legitimate expectation that these disabled persons would be able to live in the new house as long as they required, in accordance with a lawful promise that was made to them before moving to the new house at that time. As explained by the court:

“... the applicant and her fellow residents were justified in treating certain statements made by the Authority’s predecessor, coupled with the way in which the Authority’s predecessor conducted itself at the time of the residents’ move from Newcourt Hospital, as amounting to an assurance that, having moved to Madron House, Madron House would be a permanent home for them.”<sup>683</sup>

The court went on to conclude that:

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<sup>679</sup> Para 4

<sup>680</sup> Para 4

<sup>681</sup> The Times, July 12, 1996

<sup>682</sup> *R* versus North East Devon Health Authority, ex parte Coughlan 47 BMLR 27

<sup>683</sup> Para 84

“We have no hesitation in concluding that the decision to move Miss Coughlan against her will and in breach of the health authority’s own promise was in the circumstances unfair. It was unfair because it frustrated her legitimate expectation of having a home for life in Madron House. There was no overriding public interest which justified it. In drawing the balance of conflicting interests the court will not only accept the policy change without demur but will pay closest attention to the assessment made by the public body itself. Here, however, as we have already indicated, the health authority failed to weigh the conflicting interests correctly.”<sup>684</sup>

Up until the last three decades, the English courts had refused to entertain issues relating to clinical judgment or health care matters. The only exception was in negligence cases where patients were harmed by medical error, which are not within the scope of this thesis. This can explain why it is claimed that the courts have been reluctant to look at cases related to socio-economic rights, particularly the right to health care. In the case of *R v Central Birmingham Health Authority, ex parte Collier*<sup>685</sup>, for instance, Lord Justice Gibson indicated that the Court has no role as the general investigator of social policy and of the allocation of resources.<sup>686</sup> As will be indicated below, legal writers support this opinion too. However, in recent years, it seems that English courts have begun to take a new position. English courts, at least in case of ‘child B’,<sup>687</sup> have started to distinguish between how the government or public body allocates their resources, which is placed outside of judicial review, and the ability of the courts to examine the appropriateness of the spending,<sup>688</sup> which Mr Justice Laws considered as a legal issue rather than only a political or governmental matter.<sup>689</sup> Thus, the courts seem to have begun a new trend in allowing themselves to remark on how public resources should be allocated. The importance of such judgments is not only to draw a line between the function of the executive and that of the judiciary but also that it declares that governmental actions are not always political and so can be subject to judicial review especially when right to life at risk. However, the court of first instance accepted that in a world of scarce resources it is

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<sup>684</sup> *R v North East Devon Health Authority, ex parte Coughlan* 51 BMLR 1 para 89

<sup>685</sup> *R v Central Birmingham Health Authority ex parte Collier* 06/01/1988

<sup>686</sup> See Gibson LJ opinion in the case

<sup>687</sup> *R. v Cambridge DHA, Ex p. B* [1995] 2 All E.R. 129, [1995] 1 W.L.R. 898

<sup>688</sup> Ellie Palmer, *Judicial Review, Socio-Economic Rights and Human Rights Act*, 208

<sup>689</sup> Mr Justice Laws confess that it is not his job to make medical decision, he also went on to explain that “the Judicial review court does not generally redecide the merits of administrative decisions, ...” then he explained his role in the following words “What I must do, however, is ... determine whether there has been an error of law in the decision-making process under review.” See for details C. Ham, S. Pickard, and Institute King's Fund, *Tragic Choices in Health Care: The Case of Child B* (King's Fund Institute, 1998). 44-49

for the health authorities to decide how resources are to be allocated, for the case in question the fairness of a health authority decision was at issue, the judge stated that health authority should have considered all relevant considerations including the views of B's family. He went on to declare that in a case where a patient's life is at risk, the health authority had to explain clearly why it had decided not to fund the treatment. In this case, the judge had questioned whether the standard of reasonableness was the appropriate touchstone for legality. In light of this, Laws J thought that the decision had interfered with B's right to life, which was unreasonable.

In the opinion of many commentators such as Palmer, the first instance judgment was:

“A distinct contribution that could be made by courts in complaints about the fairness of health authority rationing decisions. His measured and qualified approach was in tune not only with the established approach to human rights adjudication in public law, but also with current policy debates about the rationing of medical services, particularly in relation to the need for health care rationing to be made explicit.”<sup>690</sup>

It had also been said that Laws J attempted to subject the health authority to 'hard look' scrutiny.<sup>691</sup> Under hard look scrutiny, some legal writers believe that the engagement of the first instance court in a review of merits in the B case under the test of irrationality was arguably legitimate.<sup>692</sup> However, in fact the B case directly touched on the child's right to life.

From the perspective of this thesis, the first instance judgment was a clear example of how courts should treat the right to health care when the patient's life is at risk. Although cost is seldom, if ever, irrelevant, when life is at stake recognition of a full right to health care would marginalise its importance to decision-makers. Had this judgement stood, it would have gone some considerable way towards recognising that there could be a recognised human right to health care. The most important issues would then relate not to cost, but rather to the medical assessment and the availability of however, the Court of Appeal did

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<sup>690</sup> Palmer, E. *Judicial Review, Socio-Economic Rights and the Human Rights Act (Human Rights Law in Perspective)*. 1 ed: Hart Publishing, 2007.

<sup>691</sup> Ian Turner, *Judicial review, Irrationality, and the Limits of Intervention by the Courts*, 2010, *King's Law Journal*, 21, 315

<sup>692</sup> *Ibid*, 317

not focus on human rights issues. Instead, it focused on the health authority's right to allocate its budget in a way that enabled it to achieve its targets.<sup>693</sup>

In *R v Cambridge Health Authority, ex parte B (A Minor)*, the court refused a judicial intervention in a medical judgment by stating clearly that:

“...We (Judges) should be straying far from the sphere which under our constitution is accorded to us. We have one function only, which is to rule upon the lawfulness of decisions. That is a function to which we should strictly confine ourselves.”<sup>694</sup>

Clearly, the Court of Appeal stated that courts are not empowered to question the merits of medical judgment which is beyond their jurisdiction.<sup>695</sup> While a right to health care does not mean a right to be healthy it could mean a right to reduce the degree of pain or prolong a person's life even by 20%, as was said to be possible in this case.<sup>696</sup> In this case, the assessment of the child's health condition by the doctors transpired to be wrong in that she was not expected to live beyond March 1995 but she actually lived until May 1996, following funding of the treatment under question by a private individual. However, this case has to be read in light of another decision, *Re J (a minor)*,<sup>697</sup> in which the court considered whether it was an abuse of judicial powers for a court to order a doctor to treat a patient.

In this context, the Court of Appeal may have been right not to accept the judgment of the court of first instance, given that judicial review cannot be used to allow courts to intervene in Executive decisions or medical assessments in so far as they can be described as reasonable and appropriate. However, were health care to be recognised as a human right arguably the first judgment would have been vindicated.

Therefore, we have to see the difference between justiciability in non-human rights situations and what may happen if we actually acknowledge the existence of a human right. In the B case, the judiciary based the ultimate decision on existing rules and the distinction between judicial and Executive authority. Viewing health care as a human right would, however, place decisions in a different context, starting from a presumption of

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<sup>693</sup> For case B detailed discussion see J.K. Mason, G. T. Laurie, Mason and McCall Smith's Law and Medical Ethics, 8<sup>th</sup> ed, Oxford University Press, 2011, 497-99

<sup>694</sup> The second general comment made by the Court of Appeal [1995] 2 FCR 485

<sup>695</sup> Emily Jackson, Medical Law, second edition, 2010, Oxford University Press, 77, see also Peter Leyland and Gordon Anthony, Text Book on Administrative Law, 7<sup>th</sup> ed, Oxford University Press, 2013, 183

<sup>696</sup> For details of this case see C. C. Ham and S. Pickard, "Tragic Choices in Health Care: The Story of Child B," *London: King's Fund* (1998).

<sup>697</sup> *In re J. (A MINOR) (Child in Care: Medical Treatment)*[1993] Fam. 15

universality rather than from a presumption it is ‘right’ or ‘reasonable’ to limit availability of resources because the government does not have the money to do everything.

The above judicial position not to examine health policy or medical judgments was not sustained for much longer because of the evolution of human rights. Thus, a health care right does not only influence the right to life but also the right to have a family, legal status and so on. A good example of this is *R v North West Lancashire Health Authority*.<sup>698</sup> In this case, applicants challenged the health policy not to fund a gender reassignment surgery that was adopted by the health authority. Such surgery had not scientifically been tested yet at that time. Exceptions to this policy could be discussed only where there were serious clinical needs. In light of these circumstances, and after the health authority refused to refer the applicants to the only specialist clinic concerned with this surgery, the applicants brought proceedings for judicial review.

In the courts, the decision of the health authority was quashed; however, judges in both the court of first instance and the court of appeal highlighted that the setting of priorities and the allocation of resources were matters of judgment for each authority, which needs only to keep in mind its legislative duty to take into account the reasonable requirements of all those within its remit.

After discussing what the health authority should take into account in order to set a reasonable, effective and coherent health policy which is itself, as the court stressed, an obligation on the authority, the court went on to evaluate the policy itself. The judge underscored that the authority was wrong when it did not consider transsexualism as an illness and, as a result of this error, the applicant had not even qualified for exceptional status.<sup>699</sup>

These reasons led the court to conclude that it would quash the authority’s 1995 and 1998 policies. In the court’s words:

“...they concern gender reassignment treatment and the decisions of the subjects of this appeal based on them, and remit the matter to the authority for reconsiderations of its policy and the decisions on their individual merits. The authority should reformulate its policy to give proper weight to its acknowledgement that transsexualism is an illness, apply that weighting when setting its level of priority for treatment and make effective provision for

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<sup>698</sup> *R. versus North West Lancashire HA Ex p. A*[2000] 1 W.L.R. 977

<sup>699</sup>[1999] All ER (D) 911, McHale, Fox, and Murphy, *Health Care Law: Text and Materials*. 57

exceptions in individual cases from any general policy restricting the funding of treatment for it.”<sup>700</sup>

Despite making reference to the European Convention, which was an informal source for English law, the court highlighted two significant points. The first point is that the court indicated the complicated nature of transsexualism, which can raise different scientific, moral, legal issues such as legal personality and gender, and social matters and, as a result, the contracting states would have different views when they dealt with such an issue. The second point is that, in general, a right to health care is not directly protected by the Convention and even if it were included, the power of the authority to determine health care priorities is still wider and constrained by its limited resources.

Another illustration of English judicial reviews of health authorities’ decisions and their allocation of resources was in relation to the availability of medications, when patients request a certain drug to be funded or that it be made available for use in public health institutions for patients in need. In *R v North Derbyshire HA, ex parte Fisher*, for example, the court criticised the health authority policy of not funding the drug Betainferon.<sup>701</sup> In 1999, a similar action for judicial review succeeded in *R v Secretary State for Health*,<sup>702</sup> when the drug company Pfizer challenged a health service circular issued by the Minister of Health to limit the prescription of Viagra by GPs. The court initially stated that “Compatibility of the circular with domestic law advice or guidance by a public authority could be the subject of judicial review if it contained an error of law...”<sup>703</sup> The court went on to clarify how paragraph 43 of Schedule 2 of the Terms of Service of doctors set out in the National Health Service (General Medical Services) Regulations 1992 should be understood. In the opinion of the court, there is no duty on doctors to prescribe a drug unless it is necessary and appropriate to do so.

Interestingly, the court also made reference to the European Union law, particularly Article 28 EC and the transparency of measures regulating the pricing of medicinal products Directive 89/105. The most important point indicated here by the court was that the restrictions made by the Minister of Health were justified and based on objective reasons. The court also highlighted that, in fact, there was no ban on doctors prescribing Viagra but

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<sup>700</sup>*R.v North West Lancashire HA Ex p. A* All England Official Transcripts (1997-2008) 13

<sup>701</sup> *R v North Derbyshire Health Authority, ex parte Fisher* 38 BMLR 76

<sup>702</sup> *R. v Secretary of State for Health* [1999] 3 C.M.L.R. 875, see also McHale, Fox, and Murphy, *Health Care Law: Text and Materials*.63

<sup>703</sup> [1999] 3 C.M.L.R. 875, J. Montgomery, *Health Care Law*, 2<sup>nd</sup> ed. (Oxford University Press, 2002). 62

that they must act in a rational way, taking the cost and its implications for other patients into account when they prescribe it. In relation to Directive 89/105, the court ruled that there was a breach of this Directive: the public authority, here the Minister of Health, had not followed Article 7.2 of the Directive which gives the authority the power to update the data from time to time but under the condition that it be published in ‘an appropriate publication’.<sup>704</sup>

From the above judicial reviews of health decisions, it is clear that health care is no longer exclusively a governmental matter in which the judiciary is not permitted to intervene or assess how such services should be provided or who should be covered by it. As a legal duty, providers of health care, including the Ministry of Health, must formulate policy that is lawful, rational and appropriate and that takes into account the complexity of these services. As indicated above, the right to access health care, as part of the right to health care, can raise links to economic, scientific, moral, legal and social matters. These matters should be accounted for by health bodies otherwise an intervention by the judiciary would be possible if a challenge were brought to the courts.

It is important here to note that the English courts have made significant progress in contrast to the Libyan courts in dealing with the decisions of health authorities in the country. In fact, the English courts have succeeded in cautiously intervening without trespassing onto the powers of the executive or Parliament or exceeding their remit through such an intervention. In fact, the decisions of the courts were reasonable, as such judgments were based on general principles of law, such as non-discrimination, appropriate action, reasonable time and reaction, as well as rationality. Courts have also taken into account the general principles of European law, including those introduced by the Council of Europe, in particular the European Convention of Human Rights (ECHR) which, before 1998, was commonly used as a non-formal source of law that the courts could refer to when there was no appropriate national rule that could be implemented, or any other relevant directives produced by the European Union. Finally, the courts have borne the burden of ruling on breaches of the law by either the health or local authority but have always refrained from ruling on how the authority's decision could be corrected; thus the balance between the three branches of power in the state was preserved.

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<sup>704</sup> Council Directive 89/105 relating to the transparency of measures regulating the prices of medicinal products for human use and their inclusion in the scope of national health insurance systems ( [1989] O.J. L.40/8 ).

In 2000, the Human Rights Act (HRA) 1998 entered fully into force. The adoption of the HRA was described as a revolutionary approach<sup>705</sup> which would make huge changes in the constitutional system in the UK. As result, it appears that there was a high expectation that protection of human rights in the UK would increase, but, even though this might be true of Convention Rights where supporters believe that incorporation is needed to stop elective dictatorships,<sup>706</sup> in terms of social rights in general and the right to health care in particular, this was not necessarily the case.

In fact, the courts have not yet made any reference to the European Convention of Human Rights (ECHR) in health care cases which, as explained above, does not specifically contain a right to health care. Thus, health care has never been considered as a human right by British courts. Rather, British courts deal with health care as a legal right derived from the responsibility of the state to provide health care services to citizens. As a legal right, courts can judge the decisions of health authorities and decide whether they were rational, proportionate and reasonable, rather than adjudicating based on the standards of human rights. Moreover, it might be worth noting that, even in extreme cases, the courts did not directly protect health care but usually protected another right, such as the right to life.

From the above discussion, it appears that the implementation of health care as a human right in the UK relies much more on the willingness of the serving government and its financial priorities, rather than on the legal grounds that can be employed to achieve it. The legal foundation for the right to health care is awaiting serious and immediate action from the government to transfer its international obligations into domestic law.

In the following section, there are some examples of where health care was the key question in case law. These cases have highlighted the importance of health care for both state and citizen. They indicate that national courts in the UK, as with Libyan courts, have never considered the right to health care as a human right; in fact they did not accept the connection between the right to health care and right to life until a judgment of the ECtHR, as will be explained in the European influence section. Thus, British courts appear to be closer to the governmental view on this subject than to citizens' or patients' demands in this matter.

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<sup>705</sup>Richard. Horton, "Health and the Uk Human Rights Act 1998," *Lancet* 356, no. 9236 (2000). 1188, D. McGoldrick, "The United Kingdom's Human Rights Act 1998 in Theory and Practice," *International & Comparative Law Quarterly* 50, no. 04 (2001).901

<sup>706</sup>F. Klug, "A Bill of Rights: Do We Need One or Do We Already Have One?," *LSE Legal Studies Working Paper No. 2/2007* (2007). 4

#### **4.4.2 The Courts and the Main Problems of Health Care Services in England**

Compared to civil and political rights, social and economic rights (as already indicated, including the right to health care, which is assumed to be a precondition to enjoy both civil and political rights) are still not realised as full human rights in the UK regardless of the international commitment of the British government; in particular to European agreements as will be seen later on. As already indicated, health care has become a significant subject of court cases in the UK, not only in the case of negligence and doctors' responsibility but also in cases relating to how health funds should be spent and who should be treated, where and with which treatment.

After the Human Rights Act 1998 entered fully into force in 2000, there was an expectation that the courts would deal with human rights cases in different ways. There was no doubt that the HRA had interesting implications for the development of human rights. As a short cut, at least, the HRA brought human rights home and supported British citizens in resorting to domestic courts to enforce their rights. But in relation to health care, the HRA has added nothing specific as its focus is primarily on civil and political rights. However, this does not mean that there is no potential implication of the HRA in respect of health care and social rights in general. At least, one can assume that the HRA highlighted the need to pay considerable attention to the implementation of social and economic rights in order to enjoy political and civil rights. But in order to implement their right to health care the British still in need to go to Luxembourg and Strasburg; however the European Court of Human Rights still has limited role to play.<sup>707</sup>

It is important again to emphasise that many health care cases have been brought before the judiciary and the subjects of these cases are not always human rights related. However, this discussion will focus on the cases that deal with human rights. Therefore, cases related to doctors' responsibility, negligence and medical mistakes will not be covered. Even the examples of judgments used in this section cannot be linked directly to human rights. In fact, the main question in all of them concerned the ability of the government to offer a certain service to a patient rather than the right of the patient to be offered the specific service which he or she wanted.

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<sup>707</sup> Strasburg can play a fundamental role if English court allowed the recent case against a doctor at NHS hospital in Kent to go on. Such case might be a direct real right to health care in England, if so done the ECtHR might be involved in this issue see for more details James Meikle, Family of Down's patient sue hospital over DNR order, The Guardian, 13/09/2012 at <http://www.guardian.co.uk/society/2012/sep/13/downs-patient-hospital-dnr-order> accessed 18/10/2012

With this in mind, this section of the thesis will concentrate on how the courts have handled the right to health care on certain occasions. The discussion will consider three distinct layers. The first consists of the reasoning used by courts to extend their power to adjudicate upon issues that relate to the right to health care. The second consists of the courts' treatment of undue delay and waiting lists. The third layer of cases is related to the issue of reimbursement, which citizens may request following treatment in another Member State of the EU. The final example concerns medication, and to what extent the state is legally compelled to offer effective and new therapies or highly advanced equipment that patients require for their treatment.

#### **4.4.2.1 Litigation Concerning the Right to Health Care in the English Courts**

As has been seen, over the last three decades, courts generally have not dealt with the issue of health care as a legal right. The position of the UK courts is similar and socioeconomic rights were treated more as political or aspirational targets rather than legal rights. This may explain why it is said that the courts have been reluctant to look at cases related to socio-economic rights, particularly the right to health care.<sup>708</sup> In the *R v Central Birmingham HA* case, as explained above, the Court of Appeal stated that courts have no jurisdiction to assess a health authority's decision.<sup>709</sup> This was not only the view of the Court but also some observers such as Feldman, who put it more precisely that, in English and Scottish law, receiving medical treatment or any sort of health care is not a legal right, so such provisions cannot be enforceable nor are they justiciable.<sup>710</sup> This position has not really changed even with the enactment of the HRA 1998 which, as has been indicated, avoids touching the supremacy of the Parliament, and most importantly, did not include any provision relating to health care.

By way of clarification of the legal nature of health care, there are several cases that this thesis can rely on to explain how the courts have nonetheless outlined aspects of the right to health care as a legal issue. The first case is the case of child *B*, referred to above, where it seems that the court realised that although the judiciary, as one of the three main authorities of the state, did not have the power to deal with how the executive authority or government allocate resources, nevertheless it was in a position to examine the

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<sup>708</sup>Ham and Pickard, "Tragic Choices in Health Care: The Story of Child B." 74

<sup>709</sup>*R versus Central Birmingham Health Authority*,

<sup>710</sup>D. Feldman, *Civil Liberties and Human Rights in England and Wales*, 2<sup>ed</sup> ed. (Lavoisier Fr., 1993). 903

appropriateness of the spending decision. This was considered a legal issue, not just a political matter.<sup>711</sup> In this case, the court arguably set a new trend by allowing itself to comment on how health care decisions can be justified and what health authorities should take into account when drawing up policy. As we have seen above, the court of first instance considered that the health authority's decision not to fund a treatment for the child was unreasonable because the authority had not taken into account the views of the patient's family when they made their decision. In this case, the relationship between health care and right to life was highlighted. However in the Court of Appeal the general principles of judicial review were applied; namely, that the function of courts is to check the legality of the decision rather than its merits.<sup>712</sup>

The importance of this judgment is not only to draw a line between the function of the executive and that which relates to the judiciary but it is also to declare that government actions are not always political, and so can be subject to judicial review. Such a line has recently clearly been highlighted in the case of *H*.<sup>713</sup> Although the judge dismissed the applicant's claim; he stated clearly that in order to be subject to judicial review the decision of the health authority must be taken in a way that extended or misused the powers or responsibilities that are granted to it by parliament, which was not apparent in this case. This approach can be used to show how the courts draw lines between legal action which is subject to judicial review and other political and administrative matters which are not.<sup>714</sup>

According to Mr Justice Laws, as noted above, the court is not allowed to re-decide the outcomes of managerial decisions; however, it can review whether or not such decisions are legally reasonable. In this judgment, the judge emphasised that the decision of the health authority must be taken in a way that allows interested people, such as patients and their families, to understand the real reasons on which the decision was based.<sup>715</sup> In the same judgment, Mr Justice Laws surprisingly made reference to the European Convention which had not yet entered into force. The judge went further to highlight the value of human life in relation to health care treatment.<sup>716</sup> Here, it is important to note that the

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<sup>711</sup>Ham and Pickard, "Tragic Choices in Health Care: The Story of Child B." 74, Forman, "Ensuring Reasonable Health: Health Rights, the Judiciary, and South African Hiv/Aids Policy." 714

<sup>712</sup> J.K. Mason, G. T. Laurie, Mason and McCall Smith's Law and Medical Ethics, 8<sup>th</sup> ed, Oxford University Press, 2011, 498 and Emily Jackson, Medical Law, second edition, 2010, Oxford University Press, 77

<sup>713</sup>The case of "*H*" versus *The Human Fertilisation and Embryology Authority* 2002 WL 45275

<sup>714</sup>The case of "*H*" versus *The Human Fertilisation and Embryology Authority* 2002 WL 45275

<sup>715</sup>Ham, Pickard, and King's Fund, *Tragic Choices in Health Care: The Case of Child B*. 74

<sup>716</sup>Times, The (London, England) - Wednesday, March 15, 1995

value of human life as a Convention right formed the legal starting point for the status of the right to health care and the role of the court in its enforcement.

This position was not welcomed by the Court of Appeal and the House of Lords at that time. Therefore, these judgments were overturned and British courts did not generally accept the relationship between the right to health care and the right to life until the European Court of Human Rights used this linkage in its judgments, as will be explained. English courts then started to employ the exceptional circumstances criterion for providing health care to a patient in need and, when his life is dependent on such a provision, for it to be continued.

Recently, the British courts have had opportunities to exercise these judicial norms. In *JA (Ivory Coast), ES (Tanzania) v Secretary of State for the Home Department*<sup>717</sup> and *GS v Secretary of State for the Home Department*<sup>718</sup>, the courts decided there were no exceptional circumstances that demonstrated that the decision of the Home Department was in breach of article 3 of the European Convention.

Both the High Court and the Court of Appeal<sup>719</sup> in the UK refused the applicant's request to be given leave to remain in the UK due to his health condition. However, it could be argued that because the Convention at the time was not yet incorporated into English law, and the UK courts were not bound to implement its obligations in this matter, the position of the government was different. However, the Convention requires all Member States to make sure that their legislation and actions are compatible with Convention rights.<sup>720</sup>

In general, it can be concluded that, without the judgment of the European Courts (which from Brems' view is a result of a wider interpretation of the scope of civil and political rights rather than their having been considered as social rights<sup>721</sup>) British courts were not willing to deal with health care as matter of human rights but only as a legal duty which the state has to deal with in an appropriate way. It might also be important here to note that, in dealing with the question of the legal nature of health care and by way of comparison

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<sup>717</sup>Court of Appeal (Civil Division), *JA (Ivory Coast), ES (Tanzania) versus Secretary of State for the Home Department*, [2009] EWCA Civ 1353

<sup>718</sup>*GS versus Secretary of State for the Home Department*

<sup>719</sup>*R. versus Secretary of State for the Home Department Ex p. Davoren*, [1996] Imm. A.R. 307

<sup>720</sup>The role of courts has dramatically changed after the enactment of the Human Rights Act of 1998 which opened the door to challenge NHS resource allocation decisions, see J. V. McHale, "Law, Patient's Rights and Nhs Resource Allocation: Is Eurostar the Answer?," *Health Care Analysis* 14, no. 3 (2006).170

<sup>721</sup>Brems, "Indirect Protection of Social Rights by the European Court of Human Rights." 138-147, I. E. Koch, *Human Rights as Indivisible Rights: The Protection of Socio-Economic Demands under the European Convention on Human Rights*, vol. 101 (Martinus Nijhoff, 2009). 60

between the Libyan and the English courts, it appears that there is no significant difference between their views of health care in terms of human rights, although the reasons for their approach may differ. As explained in the Libyan context, any connection between the right to life and the right to receive health care services was dismissed by the Libyan courts, including the Libyan Supreme Court. From the point of view of the Libyan courts, this results in large part from the absence of a culture of human rights particularly within the Libyan judicial system. The English position this can be explained by the division of human rights into negative and positive rights, as well as the supremacy of Parliament.

#### **4.4.2.2 Undue Delay as a Key Element of the Right to Health Care**

Due to the limitations of available financial resources, the health authorities in most countries where health care is free of charge at the point of delivery, find themselves adopting a waiting-list policy in order to better organise the provision of health care to patients on the basis of priority of need and availability of resources. Such a policy has been criticised in several cases by patients or their families.<sup>722</sup> Therefore, patients have challenged the decision of the health authorities and the standard set for waiting lists; in particular the question has been raised about how long patients are required to wait and whether presence on a waiting list will worsen their health condition.

Although the courts have stressed the freedom of the health care authorities to arrange how and when the health service must be provided to the patient who is in need; they also recognise that this freedom does not give the health authorities absolute power. As will be seen, the judiciary has determined that waiting times have to be reviewed occasionally by the health authorities in a way that takes into account a patient's health status and the development of his or her illness.<sup>723</sup> Therefore, the health body is responsible for reorganising the waiting list from time to time and arranging it on the basis of the needs of each patient and his or her health condition.<sup>724</sup>

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<sup>722</sup>Watts Case and Case C-157/99 Smits and Peerbooms [2001] ECR I-5473.

<sup>723</sup>See Case C-372/04, Watts versus Bedford Primary Care Trust, para 78, C. Newdick, "European Court of Justice, Transnational Health Care, and Social Citizenship-Accidental Death of a Concept," *Wis. Int'l LJ* 26(2008). 855-56, F. Pennings, "The Draft Patient Mobility Directive and the Coordination Regulations of Social Security," *Health Care and EU Law Part 2*(2011). 142-143, Palmer, *Judicial Review, Socio-Economic Rights and the Human Rights Act (Human Rights Law in Perspective)*. 98

<sup>724</sup>Newdick, "European Court of Justice, Transnational Health Care, and Social Citizenship-Accidental Death of a Concept." 855, Pennings, "The Draft Patient Mobility Directive and the Coordination Regulations of Social Security."143, W. Palm and I. A. Glinos, "12 Enabling Patient Mobility in the Eu: Between Free Movement and Coordination," (2010). 533, Palmer, *Judicial Review, Socio-Economic Rights and the Human Rights Act (Human Rights Law in Perspective)*. 98

As discussed, the waiting list programme is followed by the NHS to ensure a balance between the interests of individual patients and the availability of health care resources. In fact, it should be stated that the NHS has used different techniques to reduce waiting times and waiting lists. The most recent target was a target time of seeing a patient within eighteen weeks; however there is evidence that this target might not have been met.<sup>725</sup> This may result in patients deciding to challenge the decision of the NHS.

The treatment of the waiting list or waiting time by the courts is similar to its approach to the legality of the right to health care. There is an argument about the nature of the issue in question and whether it is a matter for a court or not. In addition, the intervention of the judiciary in the matter of waiting lists was not welcomed by health authorities, which believed that the NHS and its clinicians, who have the greatest knowledge of the health condition of patients, are in the strongest position to make decisions relating to waiting lists, rather than legal professionals.<sup>726</sup> This view is supported by a number of observers who believe that waiting lists are a matter for political resolution rather than for judicial review.<sup>727</sup>

In terms of waiting lists, it is important to note that while the European Committee of Social Rights published its conclusions on UK compliance with the ESC, it underscored that waiting lists in the NHS were long.<sup>728</sup> Such waiting lists of long durations indicate that a right to health care for everyone is not ensured.<sup>729</sup> In this context, it is important to note that the courts, especially the European Court of Justice, have played a fundamental role in relation to how long a patient has to wait for treatment and his related rights if the requested treatment is not provided to the patient within a certain period of time. To close the gap between the right to have free access to health services and the capacity of the national health authorities to provide health to all those in need of it, the judiciary has succeeded in using European Law to focus on three key principles of this issue in order to solve the waiting lists' dilemma.

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<sup>725</sup>See the Briefing 18-weeks waiting times target, King's fund, August 2007

<sup>726</sup>In this discourse about the priority-setting of treatment see Keith Syrett, "Opening Eyes to the Reality of Scarce Health Care Resources? R. (on the Application of Rogers) V Swindon Nhs Primary Care Trust and Secretary of State for Health," *Public Law*, no. Win (2006).

<sup>727</sup>Hervey, "The "Right to Health" in European Union Law." 208

<sup>728</sup>Council of Europe, European Committee of Social Rights, Conclusions XV-2, Vol. 2, 2001, 600 available at [http://www.coe.int/t/dghl/monitoring/socialcharter/Conclusions/Year/XV2Vol2\\_en.pdf](http://www.coe.int/t/dghl/monitoring/socialcharter/Conclusions/Year/XV2Vol2_en.pdf) accessed 03/10/2012

<sup>729</sup>Hervey, "The "Right to Health" in European Union Law.", 208

The first principle is that the court has tried to create a clear concept of undue delay which would be unacceptable, irrespective of considerations in relation to financial resources. The second principle is that putting a patient on a waiting list for treatment by the health authorities is not on its own sufficient evidence that the health authorities have fulfilled their duty in the appropriate way, even though there is no undue delay in the waiting list.<sup>730</sup> In fact, health authorities are required to review their waiting lists regularly, taking into account each patient's health condition, degree of pain, the nature of a patient's disability and his medical history.<sup>731</sup> The third principle is that if the government cannot meet its obligation to create acceptable waiting times for a patient in its own health care system, it should allow patients to obtain such services in another state in accordance with European Law by granting a prior authorisation and giving them the right to seek a reimbursement.

Regarding undue delay, an English court relied on the opinion of the European Court of Justice to solve the 'Watts' case.<sup>732</sup> The English Court of Appeal in fact applied the ECJ opinion which concluded that the recent NHS system for granting authorisation for treatment abroad was incompatible with EU law.<sup>733</sup> However, the ECJ has regarded the provision of health services as an economic activity and it does not permit Member States to postpone providing such a service because of economic considerations. In relation to undue delay in the *Watts* case, the court made it clear that the refusal to grant prior authorisation to a patient in need because he or she was on a waiting list would not be reasonable unless the waiting times were acceptable; otherwise, the patient would be allowed to seek treatment in another Member State under article 22 of Regulation No 1408/71 or under article 49 of the EU treaty.

From the above discussion, it appears that the English courts as well as English law have not been clear about what is meant by undue delay and how it can be measured. Within this context, it also appears that courts in Britain were reluctant to link health care with human rights; they are often waiting for the first step to come from overseas. Thus, it can be concluded that if there had been no other European legal systems (whether the Council of Europe or the European Union) the right to health care in the UK probably would not be more than a legal right controlled by a national authority in a national jurisdiction. The

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<sup>730</sup>Davies, "The Effect of Mrs Watts Trip to France on the National Health Service." 160-61

<sup>731</sup>K. Sieveking and Zentrum für Europäische Rechtspolitik, *Ecj Rulings on Health Care Services and Their Effects on the Freedom of Cross-Border Patient Mobility in the Eu* (Springer, 2006). 20

<sup>732</sup>Davies, "The Effect of Mrs Watts Trip to France on the National Health Service." 159

<sup>733</sup>V. Hatzopoulos, "Health Law and Policy: The Impact of the Eu," *EU Law and the Welfare State* (2005). 121-134

concept of undue delay has opened the door for patients to seek treatment abroad as a right if the national health authority has not been able to provide it in an acceptable time. In *Watts* and the cases which precede it,<sup>734</sup> the Court accepted that a prior authorisation might be subject to certain conditions with the aim of encouraging the home state to improve its health system instead of sending its citizens for treatment in another country. The health authority is required to provide treatment within a reasonable time. If they do so, the patient would not be able to seek treatment in another country; if not they have to allow him or her to go elsewhere for treatment.<sup>735</sup> When the Court explained what ‘Undue Delay’ is it, in fact, also established a patient’s right to have access to an adequate health care service,<sup>736</sup> which is part of the right to health care as proposed in this thesis.

#### **4.4.2.3 The Right to Treatment Abroad**

In relation to the right to treatment abroad, the ‘*Watts*’ case, which relied on the opinion of the ECJ, is again significant. It is also necessary to note that, in principle, a patient in Britain has no right to have treatment abroad or to seek reimbursement from the health authority for a treatment in another country unless the health authority was unable to provide such treatment within a time corresponding to the patient’s medical needs. Therefore, this right arises in certain cases where the NHS is not able to provide the required health care or the waiting time is unacceptable, as the ECJ has stated in several cases.<sup>737</sup> As pointed out above, health authorities are obliged under EU Law to provide health care services to patients within an appropriate time and in an appropriate place.

On the other hand, it seems that the English legal system including the courts has not dealt directly with this issue and has left it to the health authorities to make up their minds about whether a patient should be authorised to have treatment abroad. Thus the health authorities have exercised this power narrowly in order to keep available resources to improve local services. This fact can be deduced from, for example, the judgment of the Queen’s Bench Division (Administrative Court) where the court refused to give

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<sup>734</sup>W. Sauter, "Harmonisation in Healthcare: The Eu Patients’ Rights Directive," (2011). 19-20, R. Baeten, B. Vanhecke, and M. Coucheir, "The Europeanisation of National Health Care Systems: Creative Adaptation in the Shadow of Patient Mobility Case Law," (2010). 23-24

<sup>735</sup> G. Davies, "The Effect of Mrs Watts Trip to France on the National Health Service." 166

<sup>736</sup>Ibid. 166

<sup>737</sup> For instance Smits and Peerbooms (1999) C-157/99, *Watts and Inizan* see Hatzopoulos, "Health Law and Policy: The Impact of the Eu." 133-134

authorisation to Mrs R for treatment abroad because the four months' waiting was a reasonable time in the NHS.<sup>738</sup>

In contrast with the UK situation, it seems that the Libyan health authorities do not have an obvious legal framework or regulation that can be used to determine whether a patient was treated at a proper time by the appropriate specialist and with the most effective cure. For example, the Libyan Supreme Court dismissed an application by a patient who had cancer (the Cancer Case) for reimbursement because he went to Switzerland seeking a cure.<sup>739</sup> However, within an acceptable period of time and in an appropriate curative manner, the health authority had issued a decision to send him for treatment abroad, albeit in another country. He was not able to benefit from the decision, however, because the resources devoted to treatment abroad were not sufficient. In order to obtain treatment in Switzerland, he borrowed money from family members and friends. On his return he showed the health authority approved documents showing the treatment costs and asked for reimbursement. The competent health authority refused to repay the money. Consequently, he sued the health authority and won the case in the Court of First Instance which ordered that the patient be repaid the cost of the treatment. However, the health authority brought the case to the Supreme Court. The Supreme Court quashed the judgment of the Court of Appeal and concluded that organising the treatment was a governmental matter and not a matter for the court.<sup>740</sup>

Cases such as this illustrate why countries such as Libya need to rethink their approach to social rights, in particular to the right to health care and why it is necessary for the state authorities, executive, legislature and judiciary bodies to alter its human rights' language and understanding to meet the requirements of both internal and external legal documents. In addition, there is a need to accelerate efforts to set in place African human rights' institutions, especially the African Court, which will also assist in creating a legal framework of human rights in this area of the world. In the Libyan case, such an institution might give a new opportunity to Libyan citizens, if they are not satisfied by the

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<sup>738</sup>English courts usually left making resources allocation to those involved by the health authority to judge such cases see C. Newdick and S. Derrett, "Access, Equity and the Role of Rights in Health Care," *Health Care Analysis* 14, no. 3 (2006). 161

<sup>739</sup> Court of Appeal, First Civil Circuit Benghazi, Case No 410/97-27/12/1998

<sup>740</sup> Libyan Supreme Court, Civil Circuit, Case No 135/46-26/07/2003

judgment of national courts, to bring their case to the African Court and embarrass the government which relies on financial reasons for their decisions<sup>741</sup>

In the case of *Watts*, the Court interpreted the right of the patient to obtain treatment in another Member State widely, to the extent that he did not need prior authorisation for it, if the state's insurance did not evaluate his or her health status adequately. In this case, the patient was permitted to seek treatment in another Member State and then ask for a refund.<sup>742</sup>

In terms of reimbursement, the European Court of Justice has also developed new fundamental principles in regard to the right of the patient to obtain reimbursement for treatment abroad. For example, the Court explained what portion of the expenses should be covered and how this should be calculated, in addition to making a decision on whether or not travel and accommodation expenses should be included. In all these principles, the Court emphasised the responsibility of the state's insurance to make payment directly to the state of residence or to the patient after he or she returns home.<sup>743</sup>

Another very important principle has been established by the courts in relation to prior authorisation. In a case where a patient is granted a prior authorisation, for example to seek treatment abroad in France and the French health authority redirects him to another health centre in another Member State, he does not need to be issued with a new authorisation.<sup>744</sup> As the ECJ has stated, the authorisation for treatment in France can be used in other Member States if such treatment was recommended by the competent health authority in the Recipient State.

#### **4.4.2.4 Medication as Part of the Right to Health Care**

Medications or drugs are a fundamental part of any health care service. Recently, it has become unquestionable that the cost of drugs accounts for the highest percentage of

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<sup>741</sup>This was clear in the UK situation when UK citizens sought to gain their rights by the European Court. Thus, the UK government was embarrassed and started to change its policy by the bringing human rights home project, see *Bringing Rights Home: Labour's Plans to Incorporate the ECHR into UK Law* (Labour Party consultation document, 1996), 11; see also F. Klug and K. Starmer, "Standing Back from the Human Rights Act: How Effective Is It Five Years On?," *Public Law*, no. Winter (2005).1, L. Clements, "The Human Rights Act-a New Equity or a New Opiate: Reinventing Justice or Repackaging State Control?," *Journal of Law and Society* 26, no. 1 (1999). 76, and N. Johnson, "The Human Rights Act 1998: A Bridge between Citizenship and Justice?," *Social policy and society* 3, no. 2 (2004).

<sup>742</sup>J.V. McHale, "Rights to Medical Treatment in Eu Law," *Medical Law Review* 15, no. 1 (2007). 100

<sup>743</sup>Pennings, "The Draft Patient Mobility Directive and the Coordination Regulations of Social Security." 143-44

<sup>744</sup>Cases of the ECJ in patients` mobility in the EU as will be explained in the coming section

spending in the health care budget.<sup>745</sup> For instance, the expenditure on health care in 2010 in the UK is estimated to be about £119 billion and about £116 billion of this was spent on medical services which include hospital services and medication.<sup>746</sup> Interestingly, cancer drugs only cost the NHS about £18 billion a year.<sup>747</sup>

In terms of medication, it is useful, before talking about the judicial reviews that relate to the decision of the health authorities with regard to drugs and their costs, to investigate the role of the National Institute for Health and Clinical Excellence (NICE) which is an “independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.”<sup>748</sup> NICE is entitled to evaluate which drugs should be funded for use in the NHS. To ensure it acts appropriately, according to its responsibilities, NICE attempts to employ different standards, such as cost effectiveness including the QALY<sup>749</sup> which is also known as the quality adjusted life year, which is used as a tool help it to take the right decisions. The establishment of NICE in 1999 aimed to create a balance between the allocated resources and the patient's interests. In this context, it should be clear that NICE does not licence drugs or new devices. The responsible body for this matter is the Medicines and Healthcare Products Regulatory Agency (MHRA).<sup>750</sup>

In addition, the decisions of NICE result from collective work, involving several concerned organisations such as patient organisations, health professionals, experts and other interested parties.<sup>751</sup> The appraisal process of NICE may be open to appeal before being

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<sup>745</sup>The Health and Social Care Information Centre, Prescribing and Primary Care Services, Prescriptions Dispensed in the Community: England, Statistics for 2001 to 2011 available at [http://www.ic.nhs.uk/webfiles/publications/007\\_Primary\\_Care/Prescribing/Prescriptions%202001%20to%202011/Prescriptions\\_Dispensed\\_2001\\_2011.pdf](http://www.ic.nhs.uk/webfiles/publications/007_Primary_Care/Prescribing/Prescriptions%202001%20to%202011/Prescriptions_Dispensed_2001_2011.pdf) accessed 30/09/2012

<sup>746</sup>See the link about UK public spending online at [http://www.ukpublicspending.co.uk/uk\\_health\\_care\\_spending\\_10.html#ukgs30240](http://www.ukpublicspending.co.uk/uk_health_care_spending_10.html#ukgs30240) accessed 08/11/2012

<sup>747</sup>J. Hope, Cancer patients in the UK have 40% less spent on medication, 17<sup>th</sup> February 2010, mailonline, available at <http://www.dailymail.co.uk/health/article-1251579/Cancer-patients-UK-40-spent-medication.html> . accessed 04/05/2010

<sup>748</sup>See the website of the NICE at <http://www.nice.org.uk/aboutnice/>

<sup>749</sup>Newdick and Derrett, "Access, Equity and the Role of Rights in Health Care." 161-62, K. Syrett, "Nice and Judicial Review: Enforcing 'Accountability for Reasonableness' through the Courts?," *Medical Law Review* 16, no. 1 (2008). 130-138

<sup>750</sup>T. Poole, *Nice Technology Appraisals* (London: the King's fund, 2008). 2

<sup>751</sup> Good example Cancer Help UK at <http://cancerhelp.cancerresearchuk.org/> accessed 18/10/2012

issued in a final form such as the case of the Herceptin patient who had challenged a decision of NICE in court.<sup>752</sup>

In fact, the selection of which medicines can be prescribed on the NHS has been the subject of some dispute for several reasons. The first reason is that the concept of ‘cost effectiveness’ that is employed by NICE is not clear.<sup>753</sup> The second reason is the amount of time that NICE usually takes to decide whether or not certain drugs or new technology can be offered by the NHS.<sup>754</sup> As will be seen, a good example of this situation is Herceptin.<sup>755</sup> Since its establishment, NICE has faced much criticism in regard to its decisions, especially in relation to the cost of cancer drugs.<sup>756</sup> Although, the work of NICE is valued by some observers<sup>757</sup> its methods are often imperfect.<sup>758</sup> As a result patients in England and Wales were not able to access effective medications that were in use in other European countries and in the USA.<sup>759</sup>

Looking at judicial reviews relating to drugs as part of the right to health care, both aggrieved patients and pharmaceutical companies may challenge NICE’s decisions in the courts. For the purposes of this thesis, the focus will be on the cases that have arisen between patients and NICE, not least because the legal route most likely to be taken when companies protest NICE’s decisions is more likely to be competition law, rather than anything approaching a right to health care. In the case of *Mrs Rogers*<sup>760</sup>, the Court of

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<sup>752</sup>R (on the application of Ann Marie Rogers) versus Swindon NHS Primary Care Trust, [2006] EWCA Civ 392

<sup>753</sup>D. Parkin and J. Appleby N. Devlin, "Written Evidence for the House of Commons Select Committee Inquiry on Nice." (London: the King’s Fund), [http://www.kingsfund.org.uk/applications/site\\_search/?term=NICE&searchreferer\\_id=38&submit.x=29&submit.y=12](http://www.kingsfund.org.uk/applications/site_search/?term=NICE&searchreferer_id=38&submit.x=29&submit.y=12) accessed 5/2/2010

<sup>754</sup>Poole, *Nice Technology Appraisals*. 4

<sup>755</sup>R (on the application of Rogers) v Swindon NHS Primary Care Trust and another, [2006] EWCA Civ 392

<sup>756</sup> See J. Wagstaff, "Nasty Truth About Nice: It’s the Body That Rations Nhs Drugs. But This Leading Cancer Specialist Says Its Decisions Are Deeply Flawed," *mail Online*, 08.08. 2008. available online at <http://www.dailymail.co.uk/news/article-1042739/Nasty-truth-NICE-Its-body-rations-NHS-drugs-But-leading-cancer-specialist-says-decisions-deeply-flawed.html> accessed 3/2/2010

<sup>757</sup> M. Henderson, We need cancer drug rationing, the Times online, August 16, 2008, available online [http://www.timesonline.co.uk/tol/life\\_and\\_style/health/article4539008.ece](http://www.timesonline.co.uk/tol/life_and_style/health/article4539008.ece) accessed 10/01/2010

<sup>758</sup> See for this R. Smith, Nice decisions on drugs are flawed and tossing a coin is fairer, says academic, Telegraph.co.uk, 23 Oct 2008 available online at <http://www.telegraph.co.uk/health/3248107/Nice-decisions-on-drugs-are-flawed-and-tossing-a-coin-is-fairer-says-academic.html> accessed 6/2/2010

<sup>759</sup> ScienceDaily, Who gets expensive cancer Drugs? A Tale of two nations, 26 Dec 2009, available online [www.sciencedaily.com/releases/2009/12/091214173700.htm](http://www.sciencedaily.com/releases/2009/12/091214173700.htm) accessed 14/1/2010, see also D. Bonn, NICE taken to task over unfair decisions, 2007, *Oncology*, Vol:8, No: 3, 192

<sup>760</sup>R (on the application of Ann Marie Rogers) versus Swindon NHS Primary Care Trust, [2006] EWCA Civ 392

Appeal identified the function of NICE as being to provide national guidance on treatment and care. At the same time, the Court refused to accept the policy of the Primary Care Trusts (PCTs) not to fund Herceptin until NICE issued its next guidance. While the court confessed that it is not authorised to order the PCTs to fund the treatment, it set out several key elements that the PCTs should take into account when they reconsider their policies on patient treatment.

While the case of Mrs Rogers could be discussed in human rights terms, as will be explained in the coming paragraphs, it is not surprising that the Court of Appeal took the view that the case would be subject only to judicial review on the basis of irrationality or failure to attend to the merits of individual cases. Therefore, the court is not enabled to require the health authority to explain how it reached its set of priorities. The court went on to clarify that although health authorities have a wide discretion in arranging their priorities in light of the resources provided to them by Parliament, they should take into account the 'exceptional circumstances' of individual cases. They cannot, therefore, ignore the possibility of patients having special circumstances; otherwise any prioritisation policy is unlawful in terms of judicial review. The health authority is under a duty to explain why a patient can benefit from such policy and another one cannot. As the Court clearly stated:

“ once the PCT decided (as it did) that it would fund Herceptin for some patients and that cost was irrelevant, the only reasonable approach was to focus on the patient`s clinical needs and fund patients within the eligible group who were properly prescribe Herceptin by their physician.”<sup>761</sup>

Thus, requiring exceptional personal circumstances in order to choose between patients in need of Herceptin was considered to be irrational and therefore unlawful. As pointed out by Mason and Laurie “Ms Rogers` personal problem was, as result, not addressed-nor could it be in the context of a judicial inquiry.”<sup>762</sup>

It is essential to note that the Court of Appeal did not focus on the allocation of scarce resources but on the PCT`s policy which was irrational in the view of the court. In light of Herceptin case, in principle health policy or should not be arbitrary.<sup>763</sup> In the words of the court “The non-medical personal situation of a particular patient cannot in these circumstances be relevant to the question whether Herceptin prescribed by the patient's

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<sup>761</sup> Ibid, Para 81

<sup>762</sup> J.K. Mason, G. T. Laurie, Mason and McCall Smith`s Law and Medical Ethics, 8<sup>th</sup> ed, Oxford University Press, 2011, 388

<sup>763</sup> Elizabeth Wicks, *Human Rights and Healthcare*: Hart Pub., 2007. 32

clinician should be funded for the benefit of the patient. Where the clinical needs are equal, and resources are not an issue, discrimination between patients in the same eligible group cannot be justified on the basis of personal characteristics not based on healthcare.”<sup>764</sup>

These key elements are important in the context of this thesis, and for all those who are responsible for providing safe treatment within the scope of available resources, particularly in the case of treatments that save on costs. They also merit considerable attention when there is a requirement to decide whether or not a certain drug should be offered to a particular patient. The first key element is that the cost shall not be a matter in the assessment of the funding.<sup>765</sup> Such an element was clearly indisputable from all the case parties including the Secretary of the State for Health.<sup>766</sup>

The second key element is related to the use of off-license drugs or drugs that have not yet been recommended by NICE. In this particular situation, however, the Court emphasised the importance of the opinion of NICE in this regard, since one of its aims is to rationalise and increase the benefits of using drugs or technology for the patient and society. The third element refers to the life of the patient and how it might be threatened if he or she were not permitted to obtain the drug requested. In this context, it is important to highlight that this consideration is the basis of the right to health care in the European Union in general and particularly in the UK, as has already been noted. Finally and most importantly, the length of time it takes NICE to approve a drug for patient use, even if it is an unlicensed drug, cannot and should not threaten the life of a patient; nor should it be an excuse for NHS bodies not funding a certain drug. Thus, if the clinician believes a particular drug to be the most appropriate for the patient, the patient understands and accepts all possible side effects and the patient is classified as eligible due to his or her medical circumstances rather than personal circumstances, then the drug should be approved.<sup>767</sup>

This legal reasoning is arguably sufficient to demonstrate the right of a patient to obtain at least the essential drugs which are needed to preserve his or her life, and would be

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<sup>764</sup> Para 79

<sup>765</sup> A. Barrett et al., "How Much Will Herceptin Really Cost?," *Bmj* 333, no. 7578 (2006). C. Newdick, "Exceptional Circumstances-Access to Low Priority Treatments after the Herceptin Case," *Clinical Ethics* 1, no. 4 (2006). 205; A. Wagstaff, beyond the Herceptin hype... we need to raise the level of debate, cancer world, March-April 2006, 15 available online at [http://www.cancerworld.org/pdf/3061\\_14\\_24\\_cw11\\_GrandRound%20.pdf](http://www.cancerworld.org/pdf/3061_14_24_cw11_GrandRound%20.pdf) last seen 04/07/2011

<sup>766</sup> BBC news available on line <http://news.bbc.co.uk/1/hi/health/4311140.stm> last seen 03/07/2011

<sup>767</sup> Barrett et al., "How Much Will Herceptin Really Cost?"; Newdick, "Exceptional Circumstances-Access to Low Priority Treatments after the Herceptin Case." 206; J. Bridgeman, "'Exceptional' Women, Healthcare Consumers and the Inevitability of Caring," *Feminist Legal Studies* 15, no. 2 (2007). 238

sufficient reason for the Court to quash the decision of a health authority without the need to rely on the European Convention<sup>768</sup>

However, while British human rights' history has been remarkable since 1215, in regard to social and economic rights, the European Convention and the European Courts specifically, as will be seen in the following section, have had a particularly significant influence on how human rights, such as the right to health care, are treated by the English courts.<sup>769</sup>

International institutions and international agreements, particularly at the European level, have played a fundamental role in forcing the national courts to take human rights seriously. It is also important to note that the development of a concept of a right to health care in the UK appears to have evolved through the influence of European human rights instruments, in differing degrees, such as the European Convention, the European Court of Human Rights and the EU legal system, including the ECJ, as will be explained below. Therefore, the following section will discuss how UK courts have treated health care cases, whether there has been a need to seek advice from the judgements of European Courts and what these Courts decided in each case.

## **4.5 The Influence of Europe on the Right to Health Care in the UK**

First of all, it is important to explain that the influence of Europe on the right to health care comes from both the Council of Europe and the European Union. While the Council of Europe includes human rights as one of its major goals,<sup>770</sup> the EU developed its interest in human rights more gradually

It is also necessary to note that while it is outside the scope of this thesis to explore human rights' developments in Europe as a whole, nevertheless, the European example in human

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<sup>768</sup>C. Foster, "Simple Rationality? The Law of Healthcare Resource Allocation in England," *Journal of Medical Ethics* 33, no. 7 (2007). 405, Bridgeman, "'Exceptional' Women, Healthcare Consumers and the Inevitability of Caring." 239

<sup>769</sup>For the history of human rights in the UK and how the English courts had dealt with human rights cases before the HRA 1998 see for instance McHale, "Law, Patient's Rights and Nhs Resource Allocation: Is Eurostar the Answer?," Maclean, *Briefcase on Medical Law*.

<sup>770</sup>R. K. M. Smith, *Textbook on International Human Rights* (Oxford University Press, USA, 2007). 93, E. Bates, *The Evolution of the European Convention on Human Rights: From Its Inception to the Creation of a Permanent Court of Human Rights* (OUP Oxford, 2010). 49-51

rights is regarded as the most advanced so far in the world.<sup>771</sup> Nor will the thesis discuss the influence of the UN human rights system on the UK. For the purposes of this argument, this section will focus on the effect of the European institutions and their agents, such as the European Court of Human Rights (ECtHR) and the ECJ on the health care sectors within Member States. The aim here is to investigate whether the right to health care can be categorised as a human right rather than a legal right as it currently stands in the British legal system.

Therefore, and to clarify any confusion that may be caused by using Europe as a subtitle, this section will be divided into two subsections. The first subsection will deal with the treaties and directives issued by the European Union in relation to medical and healthcare obligations and rights. The second subsection will be devoted to the Council of Europe and its effect on health care matters in Member States by analysing the related provisions, if there are any, in the European Convention of Human Rights (ECHR) and how the ECtHR has dealt with such issues.

#### **4.5.1 The European Union (EU)**

The EU's essential aims were to integrate Europe economically. The field of human rights was not one of its objectives.<sup>772</sup> The Union emerged from integrating the European Coal and Steel Community (ECSC), the European Atomic Energy Community (EURATOM) and the European Economic Community (EEC) and became the heart of European integration.<sup>773</sup> According to Kaczorowska,<sup>774</sup> the original treaty mainly focused on economic cooperation between Member States in order to establish a common market. It has also opened the door for possible cooperation in any other area not covered by the Treaty of Rome.<sup>775</sup>

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<sup>771</sup>P. Alston and R. Goodman, *International Human Rights in Context: Law, Politics, Morals* (Oxford University Press, USA, 2007). 933

<sup>772</sup>Smith, *Textbook on International Human Rights*. 108 see also S. Greer and A. Williams, "Human Rights in the Council of Europe and the Eu: Towards 'Individual', 'Constitutional' or 'Institutional' Justice?," *European Law Journal* 15, no. 4 (2009). 470; E. F. Defeis, "Human Rights and the European Union: Who Decides-Possible Conflicts between the European Court of Justice and the European Court of Human Rights," *Dick. J. Int'l L.* 19(2000). 302

<sup>773</sup>A. Kaczorowska, *European Union Law* (Routledge Cavendish, 2008). 11;K. Davies, *Understanding European Union Law*, 2<sup>nd</sup> ed. (Lavoisier.Fr, 2001). 10

<sup>774</sup>Kaczorowska, *European Union Law*.

<sup>775</sup>The Treaty of the EC article 308 available online at <http://eur-lex.europa.eu/LexUriServ/site/en/oj/2006/ce321/ce32120061229en00010331.pdf>, see in the same meaning ibid. 11; also D. Chalmers, G. Davies, and G. Monti, *European Union Law: Cases and Materials*

There are three issues that need to be discussed in this section. The first is the development of human rights in the EU. The second is the position of health care in the EU agenda and the direct effect of the EU law on Member States. Finally, there is a discussion on the role of the judgments of the European Court of Justice (ECJ) on health care in the EU zone and how these judgments affect national health policy.

#### **4.5.1.1 Development of the EU Human Rights' System**

This section aims to explore how the EU became involved in human rights in general and health care in particular. The EU became increasingly interested in human rights as a consequence of the increasing popularity of the subject in the work of the Council of Europe and the realisation of individuals' rights, especially after the adoption of the European Convention and its judicial institution.<sup>776</sup> It was also linked to the free movement of persons in the EU zone. In order to encourage free movement of persons and goods in and between the states' members, the EU needed to guarantee that individuals will benefit from the rights that they are assumed to enjoy in their home country.

In 1997, the Treaty of Amsterdam, which came into effect in May 1999, brought human rights to the heart of the EU's aims and transformed human rights from being 'Workers' Rights' to a wider category of 'Citizens' Rights'. Since then, human rights in Europe have continued to appear as a key issue that no state or institution in the continent can ignore.<sup>777</sup> This does not mean that the priorities of the EU have dramatically changed, In fact, European economic integration is still the main target of the greater part of EU policy, although the EU has considered social policy and human rights as fundamental issues in achieving its aims.

No doubt, membership of the Council of Europe by all EU states has played an essential role in recognising the necessity of respect for human rights in the implementation of European economic integration because all States Parties of the EU are members of the Council of Europe and are subject to the provisions of the European Convention.<sup>778</sup> Such integration would not be supported by European citizens if it were working against their rights. Thus, the Treaty of Maastricht states that the Union shall respect fundamental rights

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(Cambridge Univ Pr, 2010). 232, E. F. Defeis, "Bill of Rights for the European Union, A," *ILSA J. Int'l & Comp. L.* 11(2004).. 472-73; Davies, *Understanding European Union Law.* 7

<sup>776</sup>Smith, *Textbook on International Human Rights.*108

<sup>777</sup>Davies, *Understanding European Union Law.*12

<sup>778</sup>Smith, *Textbook on International Human Rights.*108

as guaranteed by the European Convention.<sup>779</sup> In this part of the discussion, attention will be paid as to how human rights issues are treated by the EU institutions, particularly the European Court of Justice; of course, the focus will be on health care.

As pointed out by Smith,<sup>780</sup> the major aim of the EU was economic restoration of Europe. The founders did not pay great attention to human rights but they were sure that the EU would not impact negatively on human rights, not least because of the pre-existence of the Council of Europe. Therefore there was no requirement for the EU to deal with the issue.<sup>781</sup> This situation has altered since the adoption of the Treaty of Maastricht, formally known as the Treaty of the European Union 1992, and subsequent treaties, such as the Treaty of Amsterdam 1997, the Treaty of Nice 2001 and the Treaty of Lisbon 2007.

In 2000, the Charter of Fundamental Rights of the European Union was adopted at the Nice Summit.<sup>782</sup> Here, there are two points that should be highlighted; the first point is that there is a differentiation between the European Council, which is a part of the European Union and the Council of Europe. The latter is an independent European institution as already explained above. The second point is that the Charter of Fundamental Rights of the European Union 2000 is not the same document as the Convention for the Protection of Human Rights and Fundamental Freedoms or the European Social Charter 1961. These last two documents were promulgated by the Council of Europe, while the former is an instrument of the EU.

Returning to the EU human rights system, it could be argued that although human rights were likely to have been taken into account by the EU before the Treaty of Maastricht 1992, the jurisdiction of the European Court of Justice with respect to human rights was extended by the provisions of the Treaty.<sup>783</sup> Article 2 of the Treaty on the European Union (TEU) was the first legal instrument that considered human rights as EU constitutional law.<sup>784</sup> In addition, the Charter of Fundamental Rights of the European Union not only included political and civil rights but also introduced a comprehensive section on equality

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<sup>779</sup>J. L. Murray, "Fundamental Rights in the European Community Legal Order," *Fordham Int'l LJ* 32(2008).. 536-37S; S. Smismans, "The European Union's Fundamental Rights Myth," *JCMS: Journal of Common Market Studies* 48, no. 1 (2010). 49-51

<sup>780</sup>Smith, *Textbook on International Human Rights*. 108

<sup>781</sup>*Ibid.*108

<sup>782</sup> Charter of Fundamental Rights of the European Union, 2000/C 364/01, 18.12.2000, Official Journal of the European Communities C 364/1 available at [http://www.europarl.europa.eu/charter/pdf/text\\_en.pdf](http://www.europarl.europa.eu/charter/pdf/text_en.pdf) accessed 02/10/2012

<sup>783</sup>Smith, *Textbook on International Human Rights*.110

<sup>784</sup>*Ibid.*110

rights and another chapter on solidarity rights. Under the European Union human rights' system, social rights and the regulation of the rights of workers are likely to benefit from a strong enforceable system.

In terms of the judicial machinery, it is most likely that any breach of the Charter by any Member State would be monitored by the European Court of Justice, which is based in Luxembourg and is responsible for the implementation of EU law. It seems that the concept of human rights in the EU is broader than the one introduced by the Council of Europe. In addition to including social rights, the EU has also built an effective judicial mechanism. According to article 220 of the Treaty of the European Union, the Court of Justice has to ensure respect for the law whenever it interprets and applies the Treaty.<sup>785</sup> In fact, all EU institutions are required to respect fundamental rights, not only the rights mentioned in the Charter of the EU but also those rights included in the European Convention.<sup>786</sup> In the light of Article 6 (2) TEU, human rights are considered as general principles of EU Law by the Union.

With respect to the right to health care, in general it is important to note that, legally, health issues are a matter of national competence so the EU has no legal competence to adopt EU law in such matters.<sup>787</sup> However, the Charter of the EU in Article 35, now found in Part 2 of the Constitutional Treaty of 2004, has explicitly acknowledged the right of everyone to have access to preventive health care and medical care which should be provided at a high level for human health protection. It is important to note that this Charter of Fundamental Rights of the European Union is not legally binding as it is not yet incorporated into community law and was adopted only as guidelines, which can be called 'soft law', which members need to take into account when they propose new plans. Thus, health care is unlikely to be considered as a full human right in the EU. However, writers such as Menéndez believe it is a binding Treaty because it strengthens the existing law.<sup>788</sup> In this context, it is important to note that article 35 has succeeded in placing an obligation on all Member States and EU institutions to take into account human health protection and to consider it as part of any attempts to interpret or implement all EU policies and activities.<sup>789</sup> This

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<sup>785</sup>F Van Den Berghe, "The Eu and Issues of Human Rights Protection: Same Solutions to More Acute Problems?," *European Law Journal* 16, no. 2 (2010).113

<sup>786</sup>Chalmers, Davies, and Monti, *European Union Law: Cases and Materials*. 230

<sup>787</sup>T. Hervey and B. Vanhercke, "Health Care and the Eu: The Law and Policy Patchwork," (2010). 85

<sup>788</sup>A.J. Menéndez, "Chartering Europe: Legal Status and Policy Implications of the Charter of Fundamental Rights of the European Union," *JCMS: Journal of Common Market Studies* 40, no. 3 (2002).

<sup>789</sup>Charter of Fundamental Right of The European Union, article 35 available online at [http://www.europarl.europa.eu/charter/pdf/text\\_en.pdf](http://www.europarl.europa.eu/charter/pdf/text_en.pdf) accessed 08/11/2012

demonstrates the importance of the right to health care from the perspective of EU members and it also indicates that if the policies and activities are to be achieved then the realisation of the right to health care must be recognised. It seems that the EU has admitted that free movement of goods and individuals in the EU zone required a precondition such as a right to health care which should be offered to all citizens of the Member States.

To conclude, human rights were not on the agenda of the EU, so the EU institutions, including the ECJ, would only examine human rights' complaints if they had a strong, adverse effect on economic activities.<sup>790</sup> Recently, this view has changed and human rights have become a general principle of community law and a key issue in all EU policies. The importance of human rights in EU law seems apparent and is an important aspect of the protection of human rights of European citizens. This can be attributed to a number of available mechanisms in regard to decision-making in the EU. In the EU system, for example, policy can be adopted or developed by directives, decision or treaty, so EU institutions are likely to have wide discretionary powers. As already explained above, this discussion will focus on the right to health care and how the EU as an international organisation has dealt with it, and the impact of such treatment on the implementation of this right in the Member States.

#### **4.5.1.2 Effects of EU Law on National Health Care Policy**

As indicated above, protection of human rights, including the right to health care, was not the aim of the EU when it was instituted.<sup>791</sup> Nevertheless, the issue of human rights imposed itself on the EU agenda; the EU was not able to attain its goals without paying significant attention to the subject of human rights.<sup>792</sup> Creating free movement in a single market, for example, implies the existence of a health care system that is able to prevent any sort of health disaster in all member states. Moreover, one of the underlying principles of successful economic integration is the workforce, which would not be a productive element without health care. Thus, as a result, the EU was compelled to some degree to take into account health issues with regard to the free movement of goods and persons in the EU zone.

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<sup>790</sup>Van Den Berghe, "The Eu and Issues of Human Rights Protection: Same Solutions to More Acute Problems?."115

<sup>791</sup>Defeis, "Human Rights and the European Union: Who Decides-Possible Conflicts between the European Court of Justice and the European Court of Human Rights." 302

<sup>792</sup>A. Von Bogdandy, "The European Union as a Human Rights Organization? Human Rights and the Core of the European Union," *Common Market Law Review* 37, no. 6 (2000).

As seen above, this attention became increasingly noticeable after the Treaty of Maastricht (the Treaty of the European Union) when the EU for the first time made reference to human rights and also to human health protection in Article 129 (now part of Article 152). In 2000, the EU adopted its own human rights document: the Charter of Fundamental Rights and Freedoms of the European Union.<sup>793</sup> This does not mean that human rights had never been considered in the efforts of the EU.<sup>794</sup> As will be seen later on, the European Convention influenced the work of the EU, as did the regulation of the International Labour Organisation (ILO). Such influence can also be seen in the judgments of the ECJ, the responsible institution for the interpretation and application of EU/EC law. In the following discussion, the focus will be on how the ECJ has dealt with the issue of health care and the policies of the EU in relation to this subject.

Within this context, it is necessary to address the supremacy of EU law over domestic law and how it affects national legislation and institutions. As pointed out by Craig "All aspects of national law have been affected to varying degrees by our membership of the European Union. Constitutional law is no exception".<sup>795</sup> Therefore, traditional conceptions, such as parliamentary supremacy, were affected. In this study the focus will be on the direct effect of EU law. All types of EU law, except Directives have unarguably had a direct effect which, as per Craig, means that "Individuals can bring actions in their own names within national courts in order to vindicate rights secured to them by the Treaty (EU Treaty)".<sup>796</sup> In terms of the Directives that form part of EU law, commentators such as Becker and Campbell believe that Directives also have a direct effect but that such an effect can be restricted by certain conditions.<sup>797</sup> In the UK, it appears that EU Directives have a legal value in a way that requires British authorities to take them into account for any future proposed bill or policy.<sup>798</sup>

In addition, the European Court of Justice (ECJ) has played an essential role in the enforcement and interpretation of EU law and how Member States should implement it in

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<sup>793</sup>Chalmers, Davies, and Monti, *European Union Law: Cases and Materials*. 230

<sup>794</sup>Defeis, "Human Rights and the European Union: Who Decides-Possible Conflicts between the European Court of Justice and the European Court of Human Rights." 309-15

<sup>795</sup>P. Craig, "Britain in the European Union," *J Jowell and D Oliver (2007 eds)* (2007). 84

<sup>796</sup>*Ibid.* 99

<sup>797</sup>F. Becker and A. Campbell, "Direct Effect of European Directives: Towards the Final Act," *Colum. J. Eur. L.* 13(2006). 401- 26

<sup>798</sup>J. McHale, "Health Care, the United Kingdom and the Draft Patients Rights Directive: One Small Step for Patient Mobility but a Huge Leap for a Reformed Nhs?," *Health Care and EU Law* (2011). 241- 62

their own jurisdictions.<sup>799</sup> Beside these legal matters, the establishment of the EU created a new set of rights which became known as citizens' rights. In the opinion of this author, the success of the EU can be attributed to the techniques that are used and consistently developed in its functioning. Such techniques have attempted to reconcile characteristics of both international organisations and, to some extent, those of states, where there is a separation of powers and three tiers of authorities (executive, legislative and judiciary). At the same time, Member States have the right to seek abstention on certain issues. Therefore, the EU appears, at least hypothetically, to look strong in contrast with other regional organisations.

Theoretically, in the Charter of Fundamental Rights of the European Union, the right to health care, as mentioned elsewhere, is unambiguously stated in Article 35, even though the Charter was not adopted as a treaty by the Member States who disagreed over its provisions.<sup>800</sup> This might be why the ECJ still uses indirect sources to protect the right to health care but, here, it is important to remember that both the European Parliament and the Commission wanted to give the Charter of the EU a sense of compulsory obligation, especially as the ECJ, in the opinion of the Commission, is required to treat the EU Charter as an essential source of the binding principles of fundamental rights.<sup>801</sup>

With respect to the right to health care, the ECJ has relied on EU regulations and human rights rules as general principles of Community law rather than the EU Charter in safeguarding this right. In theory, it seems there is no direct source of European human rights instruments for the protection of EU citizens' health care requirements. In this context, it is important to stress that the ECJ succeeded in emphasising the supremacy of EU Community law over the National Law of Member States. EU Community law, here, means not only the treaties but also the regulations and directives involved.<sup>802</sup> This supremacy is important in filling the gap created by the non-existence of a direct treaty for the protection of health care rights. Such findings can be understood from the background of a number of judgements of the ECJ.<sup>803</sup> The foundation of health care protection is based on freedom of movement in the EU zone of goods, services and citizens, while the European Court of Human Rights has, as mentioned above, relied on the right to life for

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<sup>799</sup>See in details Chalmers, Davies, and Monti, *European Union Law: Cases and Materials*. 268-70

<sup>800</sup>D. Shelton, "Boundaries of Human Rights Jurisdiction in Europe," *Duke J. Comp. & Int'l L.* 13(2003).116

<sup>801</sup>*Ibid.* 117

<sup>802</sup>*Ibid.* 152

<sup>803</sup>Laurie GT. Mason JK Mason JK, Laurie GT, *Mason and Mccall Smith's Law and Medical Ethics*, 8 ed. (Oxford, 2011). 54,

such protection. The ECJ also relies on alternative sources, such as international human rights agreements as well as the Charter, which is not yet considered as a constitutive document.<sup>804</sup>

Discussing the role of the ECJ concerning health care as a human right requires acknowledging the fundamental principles of this task. Fundamental principles such as solidarity, citizenship and social justice were taken into account by the ECJ when it examined human rights in light of Community law.<sup>805</sup> In relation to the right to health care in particular, these principles have played an essential role in the legal reasoning of the ECJ cases, despite the argument of authors such as Newdick, who argues that the use of these principles alongside the extension of the jurisdiction of the ECJ into social rights is ‘a serious cause for concern’ for the government and its efforts to implement a stable health policy for all citizens and not only for each individual.<sup>806</sup>

In this respect, it is essential to emphasise that, in general and in accordance with its functions, the EU, in principle, is an organisation of economic integration. The ECJ considered health care as a service.<sup>807</sup> In the light of this, Newdick may be right when he states that the ECJ successfully introduced social rights, which by implication appear to be positive rights, as if these rights are negative rights.<sup>808</sup> This result is really very important in understanding the European notion of the right to health care. From the judgments of the ECJ, one can say that the right to health has not been directly protected by the European judicial institutions. In the judgments of both the ECJ and the ECtHR, a right to health care is protected in the light of other civil rights; in the case of the ECtHR health care is protected under the right to life and in the decisions of the ECJ it is protected under the right to free movement, whether of goods and services or persons.

This should not reduce the importance of these cases and shows the significance of the right to health care. In the argument of this thesis, the right to health care should be considered independently as a human right, especially if the proposed definition is accepted. The connection between a right to health care and civil rights, whether the right to life or a right to free movement, illustrates the possibility of the application of this right

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<sup>804</sup>Chalmers, Davies, and Monti, *European Union Law: Cases and Materials*.

<sup>805</sup>Newdick, "European Court of Justice, Transnational Health Care, and Social Citizenship-Accidental Death of a Concept." 852

<sup>806</sup>*Ibid.* 866-67

<sup>807</sup>*Luisi and Carbone Versus Ministero Del Tesoro* 377 403(1984).

<sup>808</sup>Newdick, "European Court of Justice, Transnational Health Care, and Social Citizenship-Accidental Death of a Concept." 857

and emphasises its capacity to be a justiciable right, a vital characteristic in human rights terms.

In this regard, the idea of workers' rights including health care is significant. In addition, enjoyment of the right to the free movement of goods, services and persons accepted by the States Members of the EU implies the existence of additional rights such as the right to health care. Thus, the question needs to be asked as to how the ECJ has influenced the health care systems in Member States. In the following section, an attempt to answer this question will be made.

#### **4.5.1.3 Right to Health Care in the Judgments of the ECJ**

First of all, it is important to note that health issues under EU law can take several forms. Firstly, health care, as an economic issue, is provided to EU citizens and is governed by competition law so it is subject to legal protection and is not a matter of human rights.<sup>809</sup> Secondly, health care is part of the free movement of goods, services and persons, which includes the right of medical professionals to work in other Member States and the right to gain access to advanced medical technology. The right to free movement is said to be one of the fundamental rights of the EU with the aim of realising the completion of economic integration between Member States but regulation of the free movement of health professionals is not dealt with in this section.<sup>810</sup> The notion of health as a service in an internal market in the EU is not accepted. As stated by Hervey and Vanhercke, health care is built upon the principle of equality of access and solidarity, rather than market deregulation.<sup>811</sup> This understanding was also developed by the Court and Commission.<sup>812</sup> For the purpose of this discussion, this section will restrict itself to questions of freedom of cross-border patient mobility in the EU and the relevant ECJ rulings in the patient health arena. Finally, it will discuss the effects of these rulings on health policy and the role of the national courts.

In regard to cross-border mobility of patients in Member States, the European Court of Justice has examined this matter in several cases and in each case the Court has interpreted the EU regulations and human rights in question in a careful way that has taken into

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<sup>809</sup>J. McHale, "Health Care, the United Kingdom and the Draft Patients' Rights Directive: One Small Step for Patient Mobility but a Huge Leap for a Reformed Nhs?," *Health Care and EU Law* (2011). 245

<sup>810</sup>Hervey and Vanhercke, "Health Care and the Eu: The Law and Policy Patchwork." 94-96

<sup>811</sup>Ibid. 96

<sup>812</sup>See cases such as Case 120/78, *Cassis de Dijon* [1979] ECR 649; Communication from the Commission concerning the consequences of the judgement given by the Court of Justice on 20 February 1979 in Case 120/78, *Cassis de Dijon*, OJ 1980 No. C256/2.

account the health situation of the patient and their individual rights. Therefore, the view of the Court has changed slightly. For example, the Court, as seen above, had supported the concern about the necessity of obtaining prior authorisation from the competent authority in the home state before travelling abroad for medical treatment; this precondition is no longer required where there is 'undue delay'.<sup>813</sup> For a further explanation of the ruling of the ECJ in relation to the right to health care, the study will briefly look at related cases one by one in a way that shows the position taken by the Court and the way in which this has reflected on patients' rights under EU law. But before studying these cases a preliminary review of the current health system is required to understand the developments. Article 8a of the EU Treaty gives every citizen of the Union the right to move and reside freely within the territory of the States Parties, subject to limitations and conditions laid down in the Treaty and subject to measures adopted to give it effect.<sup>814</sup>

The EU designed a legal basis and enacted several Directives to regulate this matter. For example, the free movement of workers and the free provision of services were arranged in D Title III of the EC Treaty;<sup>815</sup> the social security of persons moving within the EU is organised by EEC Regulation No 1408/71 of the Council.<sup>816</sup> In addition, the right of EU citizens and their family members to move into and inhabit freely the territory of Member States was regulated by the Directive 2004/38/EC,<sup>817</sup> and so on. This free movement within EU territory by Union citizens also includes students who can study or train in any Member State of the EU. Here, it is important to underline that the EU regulations apply in Member States' legal systems directly with no need for additional national measures to be taken to give them effect.

As will be seen, Regulation 1408/71, under certain conditions and specific procedures, has entitled European citizens to obtain health care while residing in a Member State other than their state of origin, irrespective of the health care system adopted by the Member States of

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<sup>813</sup> In case of non-hospital care patient has full liberalisation but in other hospital care services he may need a prior-authorisation which assumed to be proved by the State of Affiliation without delay otherwise reasons need to be justified for refusing his request, see for details Sauter, "Harmonisation in Healthcare: The Eu Patients' Rights Directive." 15-18

<sup>814</sup> Treaty of the European Community 1957, at: <http://www.hri.org/docs/Rome57/Part2.html> accessed last 09/05/2010.

<sup>815</sup> Ibid

<sup>816</sup> "Application of Social Security Schemes," in *1408/71*, ed. Council of Europe (Official Journal of the European Communities, 1971).

<sup>817</sup> "On the Right of Citizens of the Union and Their Family Members to Move and Reside Freely within the Territory of the Member States" in *Directive 2004/38/EC*, ed. The European Parliament (2004), available online at <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2004:158:0077:0123:EN:PDF> last seen in 06/07/2011

the EU, whether it is a social insurance system such as in Germany and France or a national health system that is completely controlled and financed by the State as adopted in the UK and Ireland. European citizens under specific conditions have the right to benefit from this service. The implementation of European health policy in the light of this regulation has been challenged by Member States and the European citizens. The Regulation has come before the ECJ on several occasions for interpretation.

The first case brought to the Court in relation to patients' rights was the case of *Pierik*.<sup>818</sup> *Pierik* was a Dutch pensioner who travelled to Germany for a course of hydrotherapy. After obtaining the treatment, he asked for reimbursement of the costs in accordance with article 31 of Regulation No 1408/71, which is related specifically to a retired person who needs urgent treatment while staying in another Member State. Although, Mr. *Pierik* travelled to Germany for the treatment, the health authority refused to give him authorisation because the treatment was necessary before his relocation to Germany. In such a case, the ECJ decided that, under the current conditions, authorisation for cross-border treatment should not have been rejected.

In *Decker*,<sup>819</sup> a Luxembourg health care insurer refused to make a reimbursement for a pair of spectacles that was bought by *Decker* from Belgium on a prescription issued by a Luxembourg ophthalmologist because he had not obtained prior authorisation from the organisation. In this case, the Court indicated that national health policy and social security in general had to take into account Article 28 EC on the free movement of goods. In the case of *Kohll*,<sup>820</sup> which is similar, the ECJ concluded that Article 49 of the Treaty was violated by the requirement for prior authorisation. This conclusion was rejected by Paulus and others who pointed out that:

“it must be recalled that aims of a purely economic nature (such as control of health care expenditures) cannot justify a barrier to the fundamental principle of the free movement of goods or services. A barrier can be justified however if there is a risk of seriously undermining the financial balance of the social security system.”<sup>821</sup>

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<sup>818</sup>C-117/77 *Bestuur Van Het Algemeen Ziekenfonds Drenthe Platteland Versus Pierik* 825(1978).

<sup>819</sup>ECJ, Case C-120/95 *Decher* [1998] ECR I-1831

<sup>820</sup>ECJ Case C-158/96 *Kohll* [1998] ECR I-1931

<sup>821</sup>A. Paulus et al., "Cross Border Health Care: An Analysis of Recent Ecj Rulings," *European Journal of Law and Economics* 14, no. 1 (2002). 66, R. F. Rich and K. R. Merrick, "Cross Border Health Care in the European Union: Challenges and Opportunities," *J. Contemp. Health L. & Pol'y* 23(2006). 80

Arguments revolve around the meaning and implications of these judgments particularly in regard to waiting lists and the power of the state in relation to this issue. Questions also extend as to how the state can strike a balance between the objectives of the common market and the objectives of its national social policy. The following cases might provide some answers to the above questions.

In the *Vanbraekel* case<sup>822</sup>, the Court had the opportunity to explain in detail its view. Vanbraekel was an insured Belgian citizen who requested prior authorisation for orthopaedic surgery in France. Although, the authorisation was rejected, the patient procured the treatment and sought repayment. Since the treatment was necessary, as an expert report illustrated, the Court considered it as a violation of the principle of free movement for services. In addition, the ECJ went further to conclude that the refusal to give authorisation by the health provider was not justified so the patient had the right to seek reimbursement for the cost of the treatment. In this case, the Court explained that the health provider should not restrict its authority to issue authorisation to either hospital or non-hospital care.

In *Smits and Peerbooms*,<sup>823</sup> the ECJ discussed the conditions of prior authorisation which are that the treatment should be considered as normal in professional circles and it should be necessary. However, the Court re-emphasised that the protection of national social security should not hamper the application of articles 59 and 60 (now 49-50) of the Treaty. The Court went on to explain what these conditions meant. For the first condition, the ECJ stated that 'professional circles' should mean international circles and must not rely solely on national professional opinion. In regard to the second condition, the Court concluded that it would only be justified if similar or equally effective treatment could be given without undue delay from a contracted healthcare provider, otherwise the request for prior authorisation cannot be refused.<sup>824</sup> In this context, it seems that the Court acted against the advice of the Advocate General, who argued that cross-border responsibility for health care must not be allowed because it can lead to instability in the management and finance of the health care system in Member States and that, therefore, such treatment should require prior authorisation.<sup>825</sup>

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<sup>822</sup>C-368/98 *Abdon Vanbraekel and others v. Alliance nationale des mutualités chrétiennes* [2001] ECR I-5363.

<sup>823</sup>ECJ, Case C-157/99 *Smits and Peerbooms* [2001] ECR I-5473.

<sup>824</sup>*Gerbsaets- Smits/ Peerbooms*, para. 103.

<sup>825</sup>Newdick, "European Court of Justice, Transnational Health Care, and Social Citizenship-Accidental Death of a Concept." 854

In response to the concern about public interest and the importance of the financial balance of the social security system, these factors were considered by the Court in this case. The Court ruled that prior authorisation conditions can only be reasonable if they realise the objectives of public interest standards.<sup>826</sup> This was reaffirmed in the *Müller-Fauré and van Riet* case<sup>827</sup>. These two Dutch patients demanded reimbursement for treatment in another Member State which was undertaken without prior authorisation. The requests were refused by the state of origin. While the Court concluded that prior authorisation might not be required for treatment in another Member State, considerations about external influences upon the health care system were underlined by the Court. It stated that prior authorisation would not be permitted if the patient could obtain the required treatment in the host State without undue delay. On this occasion, the Court went on to explain how undue delay could be measured. The Court ruled that undue delay is to be taken into account in assessing the request for prior authorisation and that the national authorities should assess the health status of patients frequently during their waiting time, including their health condition, their degree of pain and medical history.<sup>828</sup>

In relation to the judgments of the ECJ and its influence on the right to health care, as well as on the national health care policies of the EU Member States, in particular on undue delay, it might be significant to go back to the *Watts* case which has already been mentioned in the previous section. Some points are worth making with regard to this case. Firstly, it is a British case. Secondly, the case illustrates how a National Court and the ECJ can cooperate with each other. In this case, the Court of Appeal required the opinion of the ECJ while the case was binding at the Court of Appeal. In brief, Mrs. Watts had osteoarthritis in both hips and required a total hip replacement. Therefore, her daughter asked for authorisation to receive the treatment abroad. The request was refused because the case was classified as 'routine' and not an urgent case; the waiting time was in the region of a year. Although her health status was reconsidered and the waiting time reduced to four months, she obtained treatment in France and requested reimbursement.

However, the Advocate General reiterated the concerns about making treatment abroad open to every EU citizen and suggested restrictions on such treatment. It can be inferred that he believes this right should only be given to qualifying residents of Member States.

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<sup>826</sup>C. Sellers, "Cross Border Access to Healthcare Services within the European Union," *World Hospitals and Health Services* 42, no. 1 (2006). 25

<sup>827</sup>ECJ, Case C-385/99 *Müller-Fauré and van Riet* [2003] ECR I-4509

<sup>828</sup>Para. 90

In his view, this would mean that not all residents of Member States would be entitled to the right to travel to other Member States to obtain treatment paid for by their home state. Therefore, this group of people may be subject to the requirement of prior authorisation.

According to the Advocate General, authorisation should be based on the following conditions: (a) objective, non-discriminatory and transparent criteria; (b) made in the context of an easily accessible procedural system capable of ensuring that authorisation requests are dealt with objectively and impartially within a reasonable time, and (c) refusals can be challenged in judicial or quasi-judicial proceedings. In contrast, the Court decided that these cases are covered by the freedom to provide services. In relation to reimbursement, the ECJ stated that the patient has a right to receive full reimbursement for the expense of medical treatment received in another Member State, including the difference of the cost between their home State and the State where treatment was procured.<sup>829</sup> These judgments were in some ways not fully welcomed by Member States and jurists who considered them an intervention into national health care policies by an unelected body.<sup>830</sup> Such judgments reflect how the EU has affected the supremacy principle; namely, that EU law, including case law, has essentially acquired precedence over domestic law. Furthermore, it shows how the EU has become involved in the health policy of Member States. Most importantly, it demonstrates the development of the legal status of the right to health care which, in relation to individuals, started with the notion of workers' rights as a key element of building an internal market. At the same time, in the light of a reunited Europe, the enjoyment of the right to health care evolved from the free movement of persons in the EU zone.

Later on, the European Union took further serious steps that enhanced the Union in a way that allows Member States to act as one state. At this stage, the idea of European citizenship produced new rights including a right to health care. Hence, both Member States and the EU itself had paid special attention to health care which was a precondition for the enjoyment of other rights, as explained elsewhere in this thesis. Finally, EU law and the ECJ played a significant role in creating the notion of patients' rights.<sup>831</sup> Although the EU was not originally focused on human rights, it has taken daring and courageous steps in promoting and realising the concept of social rights and, in particular, health care,

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<sup>829</sup>Rich and Merrick, "Cross Border Health Care in the European Union: Challenges and Opportunities." 86

<sup>830</sup>A. J. Obermaier, "Models of Judicial Politics Revisited: The Ecj's Judicial Activism and Self-Restraint" (2008). 4-15

<sup>831</sup>E. Brooks, "Crossing Borders: A Critical Review of the Role of the European Court of Justice in Eu Health Policy," *Health Policy* 105, no. 01 (2012). 3

in contrast to the Council of Europe. In *Watts*, it was demonstrated how national courts were influenced by EU law and its interpretation by the ECJ. In this case, British courts requested advice from the ECJ about reimbursement and its calculation.<sup>832</sup>

To date, health care is a legal rather than a human right under EU law, even though the Charter of Fundamental Human Rights of the European Union has the potential to lead to the consideration of health care as a human right. In reality, and as indicated above, the EU Charter itself is not considered as a binding instrument or a Community law. One should not ignore the fact that the EU began to play an essential role in the legal development of health care in Member States. Recently, it is possible to see some sort of rights relating to health care such as the right to health care access, the right to choose where to gain health care services and the right to seek reimbursement. Health care as a service must also be provided with high quality standards and thus the patient, as a customer, has the right to be protected. Policies, such as patient mobility in the EU<sup>833</sup> and together for health<sup>834</sup>, have been suggested by the EU in order to monitor the health services' standards in the EU zone.<sup>835</sup>

In addition, the increasing concern about health care in the EU is reflected in health care regulations, health information networks and health promotion programmes that have been adopted by EU agents. These efforts are also supported by reasonable and objective judgments of the ECJ. These developments were generated in particular by the European Union which had increased not only its membership but also its powers over policies in Member States. Thus, at a European level, there were several regional agreements, declarations and even guidelines related to health affairs that were adopted, either by the Council of Europe or the European Union. It seems that the most important legal developments with regard to health care as a legal right, throughout this time, stemmed from the European Union.<sup>836</sup>

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<sup>832</sup>McHale, "Rights to Medical Treatment in Eu Law." 102-03

<sup>833</sup> Directive 2011/24/EU of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare, available at <http://eurlex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:088:0045:0065:EN:PDF> accessed 07/10/2012

<sup>834</sup> European Commission, Together for Health, A Strategic Approach for the EU 2008-2013, white paper, COM(2007) 630 final, Brussels, 23.10.2007 available at [http://ec.europa.eu/health-eu/doc/whitepaper\\_en.pdf](http://ec.europa.eu/health-eu/doc/whitepaper_en.pdf) accessed 07/10/2012

<sup>835</sup> See for details E. Mossialos et al., *Health Systems Governance in Europe* (Cambridge University Press, 2010).

<sup>836</sup>J. W. Van De Gronden et al., *Health Care and Eu Law* (T.M.C. Asser Press, 2011). Greer and Williams, "Human Rights in the Council of Europe and the Eu: Towards 'Individual', 'Constitutional' or 'Institutional' Justice?."

## 4.5.2 Council of Europe

It may be helpful to give some brief introductory paragraphs about the Council. The Council of Europe was established in 1949 during a particularly turbulent era following the cessation of hostilities after the Second World War. The purpose of the Council, as explained in the preamble to the Treaty of London,<sup>837</sup> is to achieve international co-operation and closer unity between Member States, to build society's respect for the democratic principles based on human rights and to reaffirm the rule of law between, and within, its members. The Council of Europe is located in Strasbourg where the European Court of Human Rights is also based. At this point, it is important to underscore that the Council of Europe and its institutions, including the Court, have nothing to do with the European Union.<sup>838</sup>

Given its expressed aims, human rights have been at the top of the agenda in the efforts of the Council since its establishment. Like the United Nations, the Council of Europe has relied on human rights to encourage its members' governments and populations to be part of the new Europe, especially in the devastating aftermath of two world wars. In this context, it is important to note that there was a differentiation between the UN human rights system which was presented in the Universal Declaration of Human Rights (UDHR) and European human rights, in the sense of implementation, application and mechanism. The latter did not only adopt a declaration about human rights but also established a monitoring body to ensure that human rights were (and continue to be) respected and enjoyed by all people within its members' jurisdiction.<sup>839</sup>

To ensure this, the Council of Europe agreed to adopt the European Convention on Human Rights (ECHR), which established the European Court of Human Rights.<sup>840</sup> In this context, the Convention is considered as the first human rights document that comes with an effective enforcement mechanism for the protection of human rights.<sup>841</sup> Both the European Convention and the Court have played a fundamental role in the protection of the rights

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<sup>837</sup>Council of Europe, European Treaty Series - Nos 1/6/7/8/11, Statute of the Council of Europe available at <http://conventions.coe.int/Treaty/Commun/ListeTraites.asp?CM=10&CL=ENG> accessed 08/11/2012

<sup>838</sup>M. Arnheim, *The Handbook of Human Rights Law* (Kogan, 2004). 2; Davies, *Understanding European Union Law*. 5

<sup>839</sup>See for example Article 19 of the European Convention on Human Rights available on line at <http://conventions.coe.int/treaty/en/Treaties/Html/005.htm>

<sup>840</sup>European Convention on Human Rights 1950, available online at [http://www.echr.coe.int/NR/rdonlyres/D5CC24A7-DC13-4318-B457-5C9014916D7A/0/ENG\\_CONV.pdf](http://www.echr.coe.int/NR/rdonlyres/D5CC24A7-DC13-4318-B457-5C9014916D7A/0/ENG_CONV.pdf) 08/11/2012

<sup>841</sup>Smith, *Textbook on International Human Rights*. 94; S. Greer, "What's Wrong with the European Convention on Human Rights?," *Human Rights Quarterly* 30, no. 3 (2008). 680-81

and freedoms of the citizens of Europe, irrespective of their nationality, gender and religion. In fact, the European human rights model became the most successful example of human rights in the world.<sup>842</sup> Although the Council focused mostly on civil and political rights as explained in the first half of the UDHR, the Court was able to take into account the social and economic components of a case whenever it had an opportunity to do so.

In 1961 the Council of Europe adopted the European Social Charter (ESC)<sup>843</sup> which was considered to be the other half of the UDHR.<sup>844</sup> The ESC included a specific article (11) on the right to health care under the term 'The right to protection of health'.<sup>845</sup> This new direction towards social and economic rights was important. However, it did not come with an effective mechanism to supervise the application of the ESC. Therefore, the monitoring of the ESC's implementation was not the remit of the European Court of Human Rights but the Commission on Social Rights by a report procedure submitted by the contracting states.<sup>846</sup>

There is not space within this thesis to explain or describe the rights that were included in the Convention, or how they were protected by the Court. Rather, this discussion will proceed directly to an investigation of whether the right to health care is one of the Convention's rights and to investigate whether the Court has looked into cases of a right to health care or not. It will then consider how the outcome of this investigation influences Member States. Reference to the ESC by the ECtHR will be highlighted where it is necessary.

#### **4.5.2.1 Right to Health Care in the Council of Europe Human Rights Instruments**

First of all, it should be recalled that the European Convention is a branch of a system of international human rights treaties. In general, the importance of the Convention was highlighted by the fact that its members agreed to accept the right of the individual petition

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<sup>842</sup>Greer, "What's Wrong with the European Convention on Human Rights? ." 680

<sup>843</sup>Council of Europe, the European Social Charter 1961 revised 1996 available on line at <http://conventions.coe.int/Treaty/Commun/QueVoulezVous.asp?NT=163&CM=8&CL=ENG> accessed 09/01/2011

<sup>844</sup>Palmer, *Judicial Review, Socio-Economic Rights and the Human Rights Act (Human Rights Law in Perspective)*.50

<sup>845</sup>European Social Charter, article 11 available at <http://www.coe.int/T/DGHL/Monitoring/SocialCharter/Presentation/ESCRBooklet/English.pdf> accessed 07/10/2012

<sup>846</sup>T. Hervey, "We Don't See a Connection: The Right to Health" in the Eu Charter and European Social Charter," in *Social Rights in Europe*, ed. G. de Búrca and B. de Witte (Oxford University Press, 2005).

and the jurisdiction of the European Court of Human Rights.<sup>847</sup> Acceptance of the Convention is not only a legal obligation but also a political commitment.<sup>848</sup> However, in terms of the right to health care, as will be seen, the Convention has never included any provision on any health care matter which the Council of Europe listed in the European Social Charter (ESC).

The significance of the Convention is also demonstrated by the positive approach that has been taken. There is an obligation on Member States to take positive actions to protect the rights of all citizens within their jurisdiction.<sup>849</sup> This is remarkable for the European states which supported the separation of human rights into two sets in the UN General Assembly. The European attitude to social and economic rights in 1966 appeared unreasonable and, as has been emphasised in the earlier chapters of this study, it reflected the ideological conflict between the West and the East during the Cold War.

In terms of the right to health care and social rights in general, it is important to note that there is nothing directly about health care in the European Convention. Indeed, the Convention has been criticised for neglecting social rights.<sup>850</sup> However, this does not mean that health care has not been a subject of dispute, in light of the Convention, and the interpretation by the Court.<sup>851</sup> In the *Cyprus v Turkey* case, the Court interpreted Article 2 (the right to life) in a way that included the provision of a right to health care.<sup>852</sup> When the Court asked the Turkish authority in North Cyprus to remove restrictions on the ability of the enclaved Greek Cypriots and Maronites to receive medical treatment it recognised that the failure to provide or permit receipt of adequate medical services gave rise to a violation of Article 2 of the Convention.

As will be seen in the next part of the thesis, this broad interpretation of Article 2 was applied by the Court in several cases. With respect to the right to health care, the European Convention is not the only human rights document that can be employed by the Court to recognise the existence of the right to health care. The European Social Charter, as will be

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<sup>847</sup>Article 24 and 25 of the Convention

<sup>848</sup>D. Harris et al., *Harris, O'boyle & Warbrick: Law of the European Convention on Human Rights* (Oxford University Press, 2009). 3-4

<sup>849</sup>See the European Convention on Human Rights, article 1 available online at <http://conventions.coe.int/Treaty/en/Treaties/Html/005.htm> accessed 05/07/2011, J.L. Jowell and J. Cooper, *Delivering Rights: How the Human Rights Act Is Working* (Hart Publishing, 2003). 13-15

<sup>850</sup>Smith, *Textbook on International Human Rights*. 10

<sup>851</sup>E. Palmer, "Protecting Socio-Economic Rights through the European Convention on Human Rights: Trends and Developments in the European Court of Human Rights," *Erasmus Law Review* 2, no. 4 (2009). 398

<sup>852</sup>*Cyprus versus Turkey* (Application 25781/94) 2001 35 EHRR 731

explained below, can also play a fundamental role in protecting this right. Nevertheless, the right to health care cannot be safeguarded by this Convention unless the judges wish to do so by adopting a wider interpretation.

Thus, after a decade, the Council of Europe began to realise the significant impact of social rights, and so the European Social Charter (ESC) was adopted in 1961 (revised in 1996). Here again, it is essential to understand that there is a significant distinction between the ESC and the European Charter on Rights and Fundamental Freedoms which is a document adopted by the European Union and not related to the Council of Europe. The former is related to the Council of Europe but it is unlike the European Convention in terms of obligations and enforcement mechanisms. However, the ESC has suffered both structural weaknesses and unwillingness of the States Parties to implement it plus the use of similar ambiguous language to that used in the ICESCR.<sup>853</sup> In this context, it is true to say that the ESC reflects the reluctance and uncertainty of Member States when considering socio-economic rights as human rights. Additionally, the ESC has, undoubtedly, taken into account the right to health care as a social right in its revised vision in 1996.<sup>854</sup> Health care is a subject of Articles 11<sup>855</sup> and 13<sup>856</sup> of the ESC in which all Member States are

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<sup>853</sup>D. Gomien, D.J. Harris, and L. Zwaak, *Law and Practice of the European Convention on Human Rights and the European Social Charter* (Council of Europe, 1996). 436

<sup>854</sup>Articles 11 and 13 of the European Social Charter

<sup>855</sup>Article 11 – The right to protection of health

With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in cooperation with public or private organisations, to take appropriate measures designed *inter alia*:

1. to remove as far as possible the causes of ill health;
2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.

<sup>856</sup>Article 13 – The right to social and medical assistance

With a view to ensuring the effective exercise of the right to social and medical assistance, the Parties undertake:

- 1 to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition;
- 2 to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;
- 3 to provide that everyone may receive by appropriate public or private services such advice and personal help as may be required to prevent, to remove, or to alleviate personal or family want;

committed to undertaking all necessary steps to guarantee the implementation of the ESC as far as they can.

In fact, it appears that the aim of the Council of Europe in adopting the ESC in this form was to give discretionary power to Member States to offer these rights. But this does not mean that the ESC commitments are merely political propaganda; in fact the ESC has adopted a monitoring method (the European Committee of Social Rights) that can be used to ensure that the State Party has used its full capacity to fulfil its duties under the Charter.<sup>857</sup> While it is true that such a monitoring technique sometimes is not as effective as the Courts, it could nonetheless put significant pressure on the government to strive for realisation of the specified rights.<sup>858</sup>

The European Committee of Social Rights (ECSR) did not pay much attention to health care until the last decade. When the Committee recently started to interpret Articles 11 and 13, its interpretation took a similar form to the one operated by the WHO and the International Committee on Economic, Social and Cultural Rights (CESCR). As explained in the previous chapters, these bodies use a wider concept of the right to health care (health) than that proposed in this thesis, making recognition of a right to health care difficult, if not impossible. This is compounded by the ECtHR's ignoring of the ESC when it examined cases relating to the right to health care. However, the Court is allowed to take account of all human rights instruments, in particular the ESC.

To sum up, a right to health care, theoretically, is not yet a human right in the Council of Europe, unless in the case of an emergency. However, in light of the European Convention, as pointed out by Mikkola,<sup>859</sup> there are positive obligations on the State Parties to protect their nationals. Thus, State Parties are required to take all necessary steps to protect citizens from threats to life, from inhuman or degrading treatment, as well as to respect patients' rights. As will be explained below, this outcome is inferred from both the Convention and the ESC, although the Court has not cited the latter in its judgments.

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4. to apply the provisions referred to in paragraphs 1, 2 and 3 of this article on an equal footing with their nationals to nationals of other Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11 December 1953.

<sup>857</sup>See European Social Charter 1996 (revised) Part IV available online at <http://www.coe.int/t/dghl/monitoring/socialcharter/presentation/escrbooklet/English.pdf> accessed 05/07/2011

<sup>858</sup>Smith, *Textbook on International Human Rights*. 96

<sup>859</sup>M. Mikkola, "Social Human Rights of Europe," (2010). 401-13

#### 4.5.2.2 The Right to Health Care in the European Court of Human Rights

As has been explained above, a right to health care has no place in the provisions of the European Convention. As a result, the European Court of Human Rights was not allowed to deal with cases relating to rights to health care. However, because the Court is empowered to deal with all matters concerning the interpretation and application of the Convention and its protocols it has made reference to them.<sup>860</sup> It seems that the Court has used its wide jurisdiction to deal indirectly with health care matters.<sup>861</sup>

As mentioned above, the Court recognised that a right to health care is a necessary precondition for the enjoyment of the right to life in the case of *D v UK*.<sup>862</sup> It is important here to notice that this case originally was about deportation from the UK rather than health care. In this case, the Court considered that the decision of the government to reject the applicant's request to remain in the UK was a violation of Article 3. The Court concluded that sending the applicant back to his home state where there were no adequate medical services would threaten his life and put him at risk. Therefore, the government had to take into account his health condition as an exceptional circumstance in such a situation.

Similar conclusions were reached by the European Court of Human Rights in *Cyprus v Turkey* in 2001.<sup>863</sup> In the *Cyprus v Turkey* case, the Court declared Turkey responsible for not providing equal medical treatment to all its citizens living under its jurisdiction, including Greek Cypriots who suffered from discrimination, as stated in the Commission's report.<sup>864</sup> Relying on the Commission's report, the Court found evidence that the Turkish authorities were in violation of Article 3, as well as other articles of the Convention. After setting out the responsibility of Turkey under the Convention, the Court went on to specify Turkey's accountability to provide the medical services that were offered to the Turkish Cypriots also to the Greek Cypriots.<sup>865</sup>

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<sup>860</sup>Article 32 of the Convention

<sup>861</sup>About the jurisdiction of the Court see Gomien, Harris, and Zwaak, *Law and Practice of the European Convention on Human Rights and the European Social Charter*. 75-6

<sup>862</sup>Brems, "Indirect Protection of Social Rights by the European Court of Human Rights." 140-41

<sup>863</sup>*Cyprus versus Turkey* (App No 25781/94) ECHR 2001

<sup>864</sup>Brems, "Indirect Protection of Social Rights by the European Court of Human Rights." 144-45

<sup>865</sup>*Ibid.* 144

Recently, in the *N v UK* case,<sup>866</sup> the Court re-emphasised its view on the connection between the right to life and the right to health care. The Court stressed again the importance of the right to health care and the positive steps that should be undertaken by the state for the enjoyment of the right to life but ruled that the UK had not, this time, violated Article 3. The Court did not find that there were exceptional circumstances or humanitarian matters that the UK authority had not taken into account when they made their decision to send the migrant back home where there was regular HIV care and available drugs.<sup>867</sup> From the viewpoint of this argument, the importance of these judgments is not only the indirect protection of the right to health care but that they also underscored the correlation between civil and political rights and socio-economic rights in general and the right to health care and the right to life in particular. Thus, states should take both sets of rights seriously, especially under the European Convention which has adopted new perspectives in dealing with civil and political rights by giving them positive status. States Parties have an obligation to undertake positive measures in order to realise such rights, which are often perceived as negative rights. Moreover, the case of *N v UK* has also shown the power of the judiciary in relation to health matters, to determine when and how governments take the right decision and the factors that it should take into account when doing so. This intervention into governmental activity ends the debate about whether the court is permitted to redress a priority that is set by the government.

Another, and most important, point within this thesis is that the Court has used the concept of the right to life to protect health care but that it did not devote time to defining health care. It is easy to observe from its judgments that the Court has utilised similar elements of health care to those utilised in this study, that is, the right of a person to have access to medical services, regardless of background or circumstances. In all these cases, elements of the right to health care proposed here were discussed by the Court. For instance, the Court referred to the quality and standard of health care services, to access to medical care, to the availability of medication and hospital services, all of which are key factors of the right to health care as it is characterised in this thesis. In addition, it should be remembered that these services are provided on the assumption that preventive programmes pre-exist when required, that qualified and trained staff including doctors and nurses, as well as empowered public bodies, can supervise and control these services and make sure they are working in an appropriate and effective way and to a high quality, and that there are

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<sup>866</sup>*N versus United Kingdom*, (App no 26565/05), (2008) 25 BHRC 258

<sup>867</sup>*N versus United Kingdom*, para 46

standards to save life and avoid any negative effect on citizens who live within the jurisdiction of any of the Member States, irrespective of their nationality, religion or sex.

To conclude, the European Court of Human Rights, as a monitoring body of the European Convention, has nothing directly to do with health care which, as noted elsewhere, was not listed in the provisions of the Convention rights.<sup>868</sup> Even in cases such as *D*, the subject matter of the case was not strictly health care but deportation out of the UK and health care was examined from a humanitarian perspective rather than from a human rights point of view.<sup>869</sup> Another big question that remains without answer is whether, if the applicants in *D* and *N* had been British citizens or Europeans, the Court would have taken another view and discussed the right to health care more seriously. It is also surprising that the Court did not make any reference to the ESC in all these cases; not even to the 1961 version which is assumed to be binding. One might need to wait for some time to see what the attitude of the Court would be if the English courts agree to permit the making of a Do Not Resuscitate (DNR Order) over the objections of the family of a Down's patient. Such case could be a real challenge to NHS authority and the human right to health care in this country.<sup>870</sup>

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<sup>868</sup>I. E. Koch, "Economic, Social and Cultural Rights as Components in Civil and Political Rights: A Hermeneutic Perspective," *The International Journal of Human Rights* 10, no. 4 (2006). 408

<sup>869</sup>*Ibid.* 420

<sup>870</sup>James Meikle, "Family of Down's Patient Sue Hospital over Dnr Order," *The Guardian*, 13/09/2012; Brems, "Indirect Protection of Social Rights by the European Court of Human Rights."

## **Chapter V: Conclusion**

This thesis has investigated why the right to health care has not been treated as a fundamental human right that is premised on universality rather than the availability of financial resources. It has been argued that one main problem in terms of recognition of this right is a conceptual misunderstanding of its meaning which has arisen from the varied ways in which it has been described in international law. This has resulted in uncertainty as to the nature and content of the right, and has contributed to problems concerning its justiciability. Accordingly, it was argued that an appropriate definition was an essential first step towards recognising the existence of a right in this area.

Therefore, in chapter one of this thesis, it was proposed that, rather than a right to the highest attainable standard of health, or a right to health – both terms being commonly used in international law – a better definition would be a right to health care. This would avoid the confusion associated with the plethora of terms used in international law and redefine the right in a way that allows for a clear understanding of its nature and scope. For the purposes of this thesis, therefore, the ‘right to health care’ describes “the state’s responsibilities for the establishment of a preventive programme to prevent sickness and a curative programme in case of illness”. In accordance with international human rights norms, this right would be available to all citizens without discrimination

If this definition of the right to health care were accepted by the international community and individual states, then health care might be seen as a legal right and courts could play an essential role in its implementation. Legal rights are usually protected by courts so any such right has the force of law, permitting citizens to challenge state failure to provide adequate resources. In considering this question of justiciability, it was argued that the historical separation of rights into different categories, based as it was on ideological considerations, could and should be abandoned in order to ensure that individuals are indeed able to claim this ‘right to health care’.

At present, however, it is difficult to categorise health care as a full and universal human right. The nature of international law does not currently accommodate any such right. Therefore, if legitimate claims to health care are to be respected, it is necessary to develop a legal framework in which the core of a right to health care is clear and recognised. That this is feasible can be seen from the example of the UK which, while not specifically recognising a human right to health care, has nonetheless developed a system that seems to accept the basic tenets of the right, as well as having recognised its justiciability. While it has been argued here that this situation is not perfect, it nonetheless does provide a template which can be followed by other states – such as Libya – if the will to recognise health care as a human right is absent. There is nothing in the pre-existing Libyan

Constitution nor in the revised draft that would prevent the adoption of a model similar to that adopted in the UK, and parallels can also be drawn between the UK's relationship with supra-national bodies, such as the EU and the Council of Europe and Libya's membership of Pan-African organisations which may in the future become more significant. As has been argued, however, implementation of this model would require that the new Libya fosters a culture of human rights, backed by executive and legislative support, and supported by an active judiciary.

Although international human rights law does not at present contain this specific right, it became clear, on analysis of relevant case law, that in many cases states have circumvented this problem by treating the right to health care as an aspect of other rights, thereby rendering it in large part justiciable. In addition, at international level, all UN Member States have ratified at least one core international human rights treaty which generally includes an article about the right to health (or as this thesis proposes the right to health care). Further, the question of justiciability, while not uncontroversial, seems to have been settled, given that both national and international courts have dealt with questions of access to certain aspects of health care as a legal issue. Analysis of European and UK jurisprudence shows that the judiciary both can and does become involved in health care related disputes.

In Europe, the European Court of Justice (ECJ) has been influential in this area. In several cases it has required EU member states to reconsider their health care policy and take the rights of the patients seriously, by providing a good health care service in reasonable time within their own countries or to allow them seek it in another EU state and be reimbursed for the associated costs. These developments have taken place not within a human rights context, but in relation to fundamental principles of the EU, namely the free movement of workers and of services.

The other European example comes from the European Court of Human rights (ECtHR) which, although it is not directly concerned with health care, is the main machinery of human rights protection in the region. Although there is no right to health care contained in the European Convention of Human Rights, the ECtHR has on occasion dealt with it indirectly in exceptional cases, for example in cases concerning deportation (*D v United Kingdom*)<sup>871</sup> as has already been discussed.

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<sup>871</sup>Brems, "Indirect Protection of Social Rights by the European Court of Human Rights.", Koch, "Economic, Social and Cultural Rights as Components in Civil and Political Rights: A Hermeneutic Perspective." 420

The model derived from European and UK practice was then compared and contrasted with the situation in Libya, where the government has also signed up to human rights conventions such as the ICESCR and the African Charter and even enacted the Health Act of 1973, with the declared aim of implementing health care rights. However, while health care rights were ostensibly recognised under the previous Libyan regime, in reality little was done to put in place the mechanisms that would allow them to be vindicated by citizens. If Libya is to meet its international commitments in this area, radical reform will be needed to ensure both that citizens have access to healthcare and to ensure that they can challenge any failures by the state to make adequate provision of these services. In this respect, Libya has much to learn from the European model. Given that Libya is currently working to draw up a new constitution in the post-Gaddafi era, the opportunity to reap the benefits of the lessons that can be learned from the European model is real. In general, it appears that Libya is ready to take such a step; for example, Libya's National Transitional Council (NTC) passed a constitutional declaration in 2011 emphasising the obligation of the state to provide health care to all citizens.<sup>872</sup> If clear provision of a right to health care is included in the new constitution this will not only define health care as a legal right but also as a constitutional one. Of course, even if only for domestic purposes, Libya could declare health care to be a human right, but arguably a more likely response will be to adopt a model such as that which exists in the UK.

The lessons that the new Libya can learn include the importance of adopting a definition of the legal right that is clear and unambiguous, such as that argued for in this thesis, thereby avoiding the problems that have confronted the international community. Further, it will be important that Libyan citizens are aware of their right to challenge decisions in courts of law and that the judiciary is both willing, and authorised, to adjudicate on any such disputes. Fostering a culture of human rights will go some way towards empowering citizens and focusing the courts on important issues relating to the right to health care. This will require a radical rethinking of the role courts play in disputes against the state in Libya.

There are many areas in the provision of health care in which Libya can learn from UK. These include administration, legal, financial, judicial review and most important the relationship between health care and human rights. In terms of administration, health care services in the UK have been questioned on matters such as structure, the relationship between central health authorities and local health bodies and the relationship between

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<sup>872</sup> Libya, Constitutional Declaration 2011, in Arabic available at [http://www.wipo.int/wipolex/en/text.jsp?file\\_id=245125](http://www.wipo.int/wipolex/en/text.jsp?file_id=245125) accessed 08/11/2012

health professionals. The establishment of NICE is also another example of a lesson that Libya can learn from UK. The creation of a similar body in Libya would allow for control over cost effectiveness, the licensing of new drugs for use in the public sector and may facilitate the availability of advanced technology for patients. From the British experience, Libya can also learn how to distribute powers between health bodies and within each authority. Moreover, Libya may, administratively, need to establish complaint mechanisms allow patients to challenge decisions of the health authorities. Such mechanisms must be designed in a way that guarantees a fast, sufficient and timely response.

In addition, Libya can also benefit from strategies that are used by British health authorities to reduce waiting times. However, it will be necessary as a preliminary, but fundamental, step to create or restore public confidence in the services that are provided. It is significant that in the few cases raised in Libyan courts, the primary issue has not directly been the failure to deliver adequate health care in Libya but rather has been the funding of treatment in another country.

In terms of legal matters, first of all, Libya needs to show a real will to implementing its human rights commitments which, in many ways, are theoretically similar, to the UK's commitments. In practice, however, there are significant differences. For instance, Libya has not yet declared its acceptance of the jurisdiction of the African Court of Justice and Human Rights to hear cases brought directly by Libyans. Such acceptance could have a significant effect on the recognition and vindication of human rights in Libya. In this context, a declaration of patients' rights might be helpful, but most important would be the creation of mechanisms that enable any such statement to be translated from rhetoric into reality. It has been noted already that challenges to health case decisions in Libya have tended to be raised in civil rather than administrative courts, although the latter are in fact the competent authority for challenging of the actions of public bodies. In contrast with the UK, the use of civil courts led to a focus on how to obtain compensation rather than on whether the government action was lawful or unlawful. In general, Libyan courts will need to be more effective in dealing with cases related to human rights and must be seen as an effective mechanism for their protection.

In addition, The African Court of Justice and Human Rights might, in the future, be a vehicle that allows African people to challenge the state's decisions, just as European citizens can use the European Court of Human Rights or the European Court of Justice of the European Union.

Recognition of the right to health care proposed in this thesis would require states to adopt a legal framework that allows all of those involved, including citizens, to be aware of their rights and duties in respect of health care. Libya, in particular, needs to develop and promote a culture of human rights in general and health care rights in particular. Ideally, this would be achieved by direct recognition of the right to health care, but – if this is not possible formally to recognise such a right – it can equally, as in the European model, be recognised as a legal right.

Even although health care is not a recognised human right in the UK or in the ECJ or the ECtHR, the terms of the right proposed in this thesis have been given legal status, not by using human rights arguments but rather by allowing for judicial review. This is one possible route that the new Libyan Government could adopt in its attempts to provide appropriate health care for its citizens within a legal framework that permits challenge from citizens when the state fails to fulfil its obligations.

Health care has long been recognised as a right in Libya, even although this did not translate from rhetoric into reality, whereas in England it has essentially been derived from social policy rather than from the perspective of human rights. Despite this, it has gained status as a right by virtue of the willingness of courts to become involved in its vindication. This is an important model that could elevate the status of health care in Libya, should the state be unwilling unilaterally to declare health care to be a human right.

This thesis was not specifically concerned with issues such as the economic, cultural or political ideologies of states. Nor was it intended to argue for the provision of a luxury level of healthcare. Rather, by clarifying the nature and status of rights in this area, it was concerned with building a platform upon which citizens and states could base the provision of adequate healthcare services and establish the legal basis for challenging failures in the provision of these services. It is as yet speculative how a future Libyan government will deal with this issue, although the early signs are promising. Adopting the form of the right advocated for in this thesis would help to clarify the way forward, as well as ensuring its justiciability. While it is accepted that, in some countries, any such right is not treated as a positive one requiring active state involvement, the models provided by the European countries suggests that it is possible – even desirable – to treat the right to health care as a fundamental legal right.

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