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Advancing the Human Right to Health ed. by José M. Zuniga,
Stephen P. Marks, & Lawrence O. Gostin (review)

Margaux J. Hall

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at CUNY Law School from 1985–1989, and has been a visiting professor at law schools in the Netherlands, Japan, and Peru, a Fulbright Scholar in Colombia, and during spring semester, 2010, he was the Tillar House Fellow at the American Society of International Law. He has consulted with law schools on curricular reform in more than forty countries worldwide. His litigation work includes representation of detainees at Guantanamo Bay, Cuba in federal courts and military commissions; several US capital cases at the Inter-American Commission on Human Rights; four cases in the Inter-American Court of Human Rights; and counsel for the European Union in friend-of-court briefs in the US Supreme Court, cited by the majority in striking down the death penalty in *Atkins v. Virginia* (2002) (persons with mental retardation), and *Roper v. Simmons* (2005) (juveniles under 18).

***Advancing the Human Right to Health* (Oxford University Press, José M. Zuniga, Stephen P. Marks, & Lawrence O. Gostin eds., 2013), 456 pages, ISBN 978-0-19-966161-9.**

I. INTRODUCTION

More than sixty-five years have passed since the Universal Declaration of Human Rights proclaimed the right of all humans “to a standard of living adequate for the health and well-being of himself and his family.”¹ In the years since, while millions of preventable deaths occur each year, the right to health has been enshrined in numerous international

and regional human rights treaties, as well as in the constitutions of over 115 countries. Human rights and health are now inextricably linked as normative and legal matters.

Human rights scholars and practitioners, in turn, have endeavored to define and effect the right to health, at times making remarkable progress, like when activists successfully challenged the South African Ministry of Health for not making drugs to prevent mother-to-child transmission of HIV widely available to the population in *Minister of Health and others v. Treatment Action Campaign and others*.² At other times, advocates have encountered frustration, stagnation, and even retrogression, like when Haiti’s citizens recently confronted a devastating cholera outbreak that the government and international community could not swiftly address.³ Notably, the right to health’s boldest expressions have often appeared in the world’s poorest and most unequal settings, while wealthier countries have frequently rejected positive framings of the state’s duties to its own citizens.

Advancing the Human Right to Health provides an insightful retrospective on the right to health advocacy and a foreshadowing of what is to come.⁴ With authors who offer a broad view of conflicts that exist in international health discourse, such as the tensions that persist between public health and human rights, the book provides a refreshing opportunity to more closely analyze and potentially

1. Universal Declaration of Human Rights, adopted 10 Dec. 1948, G.A. Res. 217A (III), U.N. GAOR, 3d Sess, art. 25, U.N. Doc. A/RES/3/217A (1948).
2. See *Minister of Health and Others v. Treatment Action Campaign and Others*, (10) BCLR 1033 (CC) (2002).
3. See Donna J. Barry, et al., *Haiti: An Overview of its Right to Health History and Future Directions*, in *ADVANCING THE HUMAN RIGHT TO HEALTH* 91 (Jose M. Zuniga, Stephen P. Marks, Lawrence O. Gostin eds., 2013) [hereinafter *ADVANCING THE HUMAN RIGHT TO HEALTH*].
4. See *ADVANCING THE HUMAN RIGHT TO HEALTH* *id.*

resolve those conflicts. Various authors also describe how the right to health has been used to remedy specific injustices at the country and community levels, allowing for cross country and experiential learning. Finally, the volume concludes by wrestling with key issues of concern for the next generation of right to health norm-setting, including the challenge of reconciling property rights with the right to share in scientific advancement, the important role of health workers as both duty bearers and rights holders, and the need to realize the right to health in emergency or disaster settings. In all, the volume assembles the voices and perspectives of some of the key implementers of right to health programming over the past several decades for an illuminating and refreshingly honest (albeit at times sobering) assessment of the movement's triumphs and shortcomings.

II. THE RIGHT TO HEALTH IN PERSPECTIVE

Section One of *Advancing the Human Right to Health* seeks to define the right to health, its importance, and the key strategies that have been used to promote the right. Providing the first discussion of a tension that runs deep within human rights conversations—that is, clarifying whether the term “human rights” refers to legal claims, moralistic claims, or both—Steven P. Marks introduces the enormous challenges that have emerged in measuring the attainment of health rights. The right to health, Marks contends, must entail something more than mere mea-

sures of biostatistical markers. It must also document progress in achieving distributive justice and other normative goals like autonomy of thought and action.⁵ What Marks does not discuss directly, but which emerges from his chapter, is the performativity of health statistics surrounding right to health programming. That is, governments, NGOs, and other players have learned to cater their programming to achieve right to health benchmarks, at times superficially, and at times skewing or obfuscating the attainment of wider health progress. That risk of superficially meeting “targets” remains endemic to right to health practice.

Subsequent chapters in this Section discuss how the right to health has been put to use, including through progressive litigation and policies like the Free Health Care Initiative for mothers and small children in Sierra Leone. In the case of right to health litigation, Oscar A. Cabrera and Ana S. Ayala point out that even the most successful health rights cases give rise to a set of concerns regarding the democratic legitimacy of courts to determine health policy.⁶ There is a real risk that courts may subvert the efforts of other branches to craft pragmatic policy in this area, and thus the authors examine how deferential courts should be to legislative and executive branches of government on health issues. The authors also interrogate the representative legitimacy of individual litigants to reflect a broader collective group of society while presenting conflicting evidence about whether litigation has indeed improved health equity.⁷ They note that, ultimately, even where courts are effective, “Implementa-

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5. See Stephen P. Marks, *The Emergence and Scope of the Human Right to Health*, in *ADVANCING THE HUMAN RIGHT TO HEALTH*, *supra* note 3, at 3, 5–11.
 6. See Oscar A. Cabrera & Ana S. Ayala, *Advancing the Right to Health Through Litigation*, in *ADVANCING THE HUMAN RIGHT TO HEALTH*, *supra* note 3, at 25, 28–35.
 7. See *id.* at 34–35.

tion [of courts' judgments] . . . depends on external contributing factors, such as pressure from civil society."⁸

The initial chapters in Section One illuminate tensions that exist between the right to health and public health more broadly. As Helena Nygren-Krug explains, while the public health community has embraced a range of models that "have 'the imprint' of human rights, the language of human rights still remains foreign."⁹ Public health officials often view human rights work as adversarial and activist, as compared to their own collaborative and evidence-based work. In similar ways, rights conversations have at times skewed resources towards addressing hot button topics, like antiretroviral drugs for HIV, rather than broader and more holistic health programs.

The authors in these sections are astutely aware of how human rights framing, while capable of vindicating certain individuals' needs, may also fall short of more expansively addressing broken health systems. They touch upon the most challenging constraints to affecting the right to health. For example, as Ariel Pablos-Mendéz and Lesley Stone explain in Chapter 4, non-communicable diseases now exact the largest toll on public health systems, being responsible for more deaths worldwide than all other causes combined.¹⁰ Yet human rights advocates and human rights-sensitive donors continue to most generously fund communicable and infectious diseases like HIV/AIDS and malaria. Further, the shifting landscape of non-state power

brokers, from pharmaceutical companies to international donors, introduces a number of interests that are not immediately subject to human rights' responsibilities. Human rights, as a field of law, has yet to fully grapple with how to meaningfully include these non-state actors in discussions of responsibility.

Other doctrinally challenging questions remain as well, including how to define benchmarks of progress and how to measure the "progressive realization" of the right to health as treaties like the Covenant on Economic, Social, and Cultural Rights require.¹¹ Ultimately, Eric A. Friedman and Lawrence O. Gostin suggest that the global community double down on its right to health approaches, pushing harder to make gains. They suggest a new framework convention on health to achieve a number of goals, such as increased incorporation of right to health obligations and principles into national laws and policies, improvement of impact litigation, and greater empowerment of communities to rise up and claim their right to health. This is an ambitious proposal for an overhaul of right to health approaches; however, it is not entirely clear how this new approach will overcome the same shortcomings that have plagued past human rights practice.

More importantly, the authors propose a treaty that would boldly reflect the voices and needs of the community members it would serve. As they presciently note, such a treaty

must speak to the realities of slum-dwellers who live near centres of power yet lack

8. *Id.* at 34.

9. See Helena Nygren-Krug, *The Right to Health: From Concept to Practice*, in *ADVANCING THE HUMAN RIGHT TO HEALTH*, *supra* note 3, at 39, 47 (internal parentheses removed).

10. See Ariel Pablos-Mendéz & Lesley Stone, *Health Development as Nation Strengthening*, in *ADVANCING THE HUMAN RIGHT TO HEALTH*, *supra* note 3, at 55, 63 (citing *GLOBAL STATUS REPORT ON NONCOMMUNICABLE DISEASES*, WORLD HEALTH ORGANIZATION (2011)).

11. Eric A. Friedman & Lawrence O. Gostin, *Pillars for Progress on the Right to Health*, in *ADVANCING THE HUMAN RIGHT TO HEALTH*, *supra* note 3, at 70.

the most basic services, to farmers who find themselves and their children without proper nourishment, and to the orphans and widows, indigenous populations, sexual minorities, women, people with disabilities, and others who often suffer the ugliest discrimination and most extreme poverty.¹²

Whatever its practical potential for revolutionizing health rights implementation, this vision, of human rights speaking in a meaningful way to those constituents, is an urgent one that resonates throughout the volume.

III. THE RIGHT TO HEALTH IN ACTION

Section Two of *Advancing the Human Right to Health* offers compelling case studies that describe efforts to meet the right to health in particular country contexts. From Haiti to South Africa, China to the United States and beyond, the authors present a tapestry of often-divergent right to health approaches. Reflecting a range of underlying political, social, and economic orders, these approaches also have different success rates.

Donna J. Barry and her co-authors illustrate through the case of Haiti that a mere legal commitment to the right to health is insufficient to move the dial. While Haiti's government has ratified various international treaties guaranteeing the right to health and has enshrined it in its own constitution, in practice the government has poorly fulfilled this right. This is due to what the authors describe

as "centuries of political turmoil, interference of other states, and an inordinately high percentage of foreign assistance and provision of care by international partners."¹³ Haiti's citizens have experienced the tragic effects of intransigence in various ways, including during a devastating cholera epidemic that swept the country from 2010 to 2012. Here, we see that rights, even as legal commitments and tools, fall short where governments are ill-equipped to govern and formulate better policies.

Raymond A. Atuguba provides a more hopeful lens into tangible accomplishments of right to health practitioners in Ghana. There, the government has implemented a landmark National Health Insurance Scheme that aims to insure all persons in the country. The insurance benefits package covers 95 percent of the country's disease burden, and by 2007, 47 percent of the population had registered for health insurance.¹⁴ Although the government is still working to address accessibility, quality control, and financial sustainability of the insurance scheme, Ghana provides a hopeful picture of how a government can design rights-sensitive health care financing.¹⁵

In South Africa, litigation has helped define the contours of the right to health and the government's corresponding obligations. According to authors Charles Ngweni, Rebecca Cook, and Ebenezer Durojaye, the South African government confronts a disease burden from communicable diseases like HIV, diseases related to poverty and challenges of development, chronic diseases such as diabetes, and injury and violence.¹⁶ The

12. *Id.* at 69, 83.

13. Barry, et al., *supra* note 3, at 93.

14. See Raymond A. Atuguba, *The Right to Health in Ghana: Healthcare, Human Rights, and Politics*, in *ADVANCING THE HUMAN RIGHT TO HEALTH*, *supra* note 3, at 101, 104–05.

15. *Id.*

16. See Charles Ngweni, Rebecca Cook, & Ebenezer Durojaye, *The Right to Health in Post-Apartheid Era South Africa*, in *ADVANCING THE HUMAN RIGHT TO HEALTH*, *supra* note 3, at 129,

country thus confronts, in a particularly extreme manner, the health burdens that both developing and developed countries face. At the same time, South Africa's Constitution creates a positive right of access to healthcare services, and, more than most other countries, South Africa has grappled with the meaning of this right through a series of court cases. The judiciary has thus emerged as a powerful player in defining and enforcing the right to health as it applies to specific citizens and the health challenges they confront. Nevertheless, as the authors of this chapter ultimately—and incisively—note, achieving accessibility of health services, as the South African Constitution guarantees, is not sufficient. South Africa's devastating experience with HIV/AIDS has revealed that residual barriers like stigma and fear must be addressed as well.¹⁷

China's example suggests the need for human rights law to be in close conversation with other areas of law that affect health, including administrative law and procedural law. As Philip D. Chen and Di Wu describe, the Chinese government has confronted health challenges emerging as its vast population experiences rapid development. Despite ratifying key international human rights treaties that protect the right to health, and despite having its own General Principles of Civil Law stating that "Citizens shall enjoy the rights of life and health,"¹⁸ China has seen food security and food safety emerge as key health issues in recent years. The

country is working to establish a regulatory system that protects the food supply from contamination and economically induced adulteration of food products.¹⁹ Yet, citizens are oftentimes hampered in contesting rights violations, as political authorities prioritize the need to maintain harmony in society over the fair adjudication of claims.²⁰ While China has made dramatic improvements in its health statistics, as long as citizens lack fair and accessible remedial channels, the right to health will continue to ring hollow.

Alicia Ely Yamin and Jean Connolly Carmalt discuss the progress and shortcomings of the United States in remedying the dramatic health disparities that the nation confronts. The United States, as the most affluent country in the world, spends more money on health care on a per capita basis than any other country.²¹ Nonetheless, millions of Americans do not have access to healthcare services, for financial or other reasons. The authors describe the complex and highly fragmented nature of the U.S. health insurance market, with the vast majority of persons obtaining health insurance through their places of employment and select others receiving insurance through government-funded safety net programs. The United States notably does not embrace a right to health as part of its juridical system. Nonetheless, as the authors describe, the country's landmark 2010 Patient Protection and Affordable Care Act promotes changes that are in line with human rights principles like

130; The Lancet, *Health in South Africa: An Executive Summary for The Lancet Series 2* available at http://download.thelancet.com/flatcontentassets/series/sa/sa_execsum.pdf.

17. See Ngweni, Cook, & Durojaye, *supra* note 16, at 139–40.

18. See Philip D. Chen & Di Wu, *China's Evolution in Progressively Realizing the Right to Health*, in *ADVANCING THE HUMAN RIGHT TO HEALTH*, *supra* note 3, at 159, 160 (citing *General Principles of the Civil Law of the People's Republic of China*, art. 98 (2012a)).

19. See Chen & Wu, *supra* note 18, at 163.

20. See *id.* at 164–65.

21. See Alicia Ely Yamin & Jean Connolly Carmalt, *The United States: Right to Health Obligations in the Context of Disparity and Reform*, in *ADVANCING THE HUMAN RIGHT TO HEALTH*, *supra* note 3, 231 (citing OECD HEALTH DATA 2011—FREQUENTLY REQUESTED DATA (2012)).

nondiscrimination. Can a right to health approach include non-rights-based strategies? What might we learn from the experience of countries who have endeavored to improve health through alternative, non-rights-based framings?

In this chapter, as in others throughout this Section and volume, one wishes that the authors could be in conversation with one another. It is left to the reader to extract the common themes of challenges and opportunities. In their own case studies, the authors lament the limited legal duties that human rights impose on states alone. Indeed, the real right to health power brokers are often private or international actors who hold the purse strings or other influence. Separately, many of the authors note that the naming and shaming of human rights can be alienating; instead, they paint hopeful pictures of constructive rights-based partnerships (between government and citizens, and otherwise) that have made a difference. Overall, the country case studies reflect a struggle to measure progress, particularly against the backdrop of the “progressive realization” framework. These tensions resonate through the chapters and merit deeper dialogue.

IV. THE RIGHT TO HEALTH: CHALLENGES AND OPPORTUNITIES

The final section of the volume consists of eleven chapters highlighting key constraints and opportunities that right

to health practitioners have confronted. Here, the experts weigh in on challenges ranging from HIV/AIDS to tobacco control, women’s health, health workforce issues, access to medical technology, genomics, and disaster and emergency settings, among other topics. The chapters reveal how earlier health challenges that served as rallying cries for the right to health, such as HIV/AIDS and women’s reproductive rights, persist to this day. At the same time, a new landscape of public health issues has emerged within the ambit of a right to health framing. Among the challenges presented by these issues is the importance of designing contextually- and culturally-appropriate right to health programs that reflect the particular values and needs of the communities that they serve. For example, the reader finds vivid examples of failed malaria programs that were not culturally acceptable²²—in Ghana, some community members have refused to use white mosquito nets out of superstitions about ghosts, while in Kenya, nets were used for fishing purposes.²³

In addition, the cooption of rights language and competing claims of rights complicate implementation. In the case of tobacco control, the tobacco industry has leveraged the language of fundamental rights to contest legal restrictions on smoking.²⁴ Similarly, in promoting access to medical products, vaccines, and medical technologies, the right to “enjoy the benefits of scientific progress and its applications”²⁵ conflicts with the right to “the protection of the moral and material interests resulting from any scientific,

22. See Britta Baer et al., *Human Rights-Based Approaches to HIV, Tuberculosis, and Malaria*, in *ADVANCING THE HUMAN RIGHT TO HEALTH*, *supra* note 3, at 245, 254.

23. See *id.*

24. See Oscar A. Cabrera & Lawrence O. Gostin, *Global Tobacco Control: A Vital Component of the Right to Health*, in *ADVANCING THE HUMAN RIGHT TO HEALTH*, *supra* note 3, at 261–67.

25. International Covenant on Economic, Social and Cultural Rights, *adopted* 16 Dec. 1966, G.A. Res. 2200 (XXI), U.N. GAOR, 21st Sess., art. 15(1)(b), U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3 (*entered into force* 3 Jan. 1976).

literary or artistic production.”²⁶ Property rights stand in tension with rights to access health care innovations. Within the same human rights convention, a seeming contradiction exists when considering how to meaningfully provide access to medical commodities.²⁷

The adversarial framing of “rights”—and corresponding duty-bearers—has proven to be alienating and counterproductive in certain settings. Indeed, as authors Stephen P. Marks and Adriana L. Benedict discuss, pharmaceutical companies could serve as powerful partners in realizing the right to health.²⁸ According to former Special Rapporteur on the right to health Paul Hunt, such companies can recognize the importance of human rights in their corporate mission statements and publicly commit to contributing to research and development, as well as to respecting developing countries’ rights to take advantage of international trade provisions that facilitate enhanced access to medical technology.²⁹ In the case of health workers, José M. Zuniga and Imane Sidibé powerfully highlight how health workers can act as both duty-bearers (being agents of the state on the front-lines of service delivery) and rights-holders (subjected to workplace discrimination and other potential rights infringements). Given the highly local and personalized relationships that exist around health care delivery, breaking apart the stark state-citizen divide in human rights conversations becomes important.

In tackling many of these issues, the language of human rights has emerged as a powerful common vocabulary.³⁰ It has clearly facilitated funding and common understanding across community, regional, and national boundaries. Yet the authors of these chapters at times use the term “human rights” loosely, without clearly delineating whether they are invoking rights as legal principles, grounded in international or domestic law, or whether they refer to human rights as normative commitments that should inspire action. This distinction is an important one, as it underlies the questions of: *why* human rights are uniquely situated to resolve health challenges; and *how* specifically human rights may do so.

Rights may, as moral claims, rally countries to action and inspire non-state actors to contribute to a globally-oriented mission to advance health. Or rights may serve as legal commitments that nation states make in international treaties, with the corresponding obligation to incorporate those commitments into their own domestic law. Or rights may serve as truly binding law on governments, who must abide by their own commitments. As Zuniga and Sidibé powerfully note: “To the extent that people believe in them, rights achieve the cultural and social legitimacy which alone confers real power behind the concept of a human right. Without a strong prior commitment to the right, there can be no progress.”³¹ This prescient insight suggests a circularity to right to health movements and a

26. *Id.* art. 15(1)(c); see also Stephen P. Marks & Adriana L. Benedict, *Access to Medical Products, Vaccines, and Medical Technologies*, in *ADVANCING THE HUMAN RIGHT TO HEALTH*, *supra* note 3, at 305.

27. See Marks & Benedict, *supra* note 26, at 305.

28. See *id.*

29. See *id.* at 309. (reflecting on the Human Rights Guidelines for Pharmaceutical Companies in Relation to Access to Medicines, which were presented to the UN General Assembly in 2008).

30. See Baer et al., *supra* note 22, at 251.

31. See José M. Zuniga & Imane Sidibé, *Primum Non Nocere and the Right to Health*, in *ADVANCING THE HUMAN RIGHT TO HEALTH*, *supra* note 3, at 335, 336.

potential conundrum. If governments (and citizens) are not *already* invested in human rights, then a legal commitment to them will likely fall short. On the other hand, where persons are inherently committed to rights to begin with, formal legal commitments to rights may inspire enhanced action and efforts.

Overall, Zuniga, Marks, and Gostin have compiled a robust volume that highlights the range of health issues challenging the global community today, as well as how a right to health framing has facilitated action in response. Human rights practitioners and academics will find fruitful examples of the shortcomings and opportunities in right to health campaigns, as well as cutting-edge insights into the public health challenges of the day. This volume by Oxford University Press is in many senses a continuation of the long, global conversation health rights advocates and scholars have had about promoting the right to health—a conversation that precedes this volume but spills richly across its pages and should certainly be continued and probed in further literature.

Margaux J. Hall*
Columbia Law School

** Margaux J. Hall is a Post-Graduate Fellow at Columbia Law School. Ms. Hall's scholarship and professional practice have focused on healthcare law, fiduciary law, human rights, environmental law, and women's rights. Ms. Hall has conducted health, governance, and human rights research in South Africa as a Fulbright Fellow and in East Africa as a Harvard University Frederick Sheldon Fellow. She also spent three years working with the Justice Reform Group of the World Bank's Legal Vice Presidency in Sierra Leone, where she collaborated closely with the government and explored the role of law in advancing healthcare in resource-constrained contexts.*

All views and errors expressed herein are the author's own.

John D. Ciorciari & Anne Heindel,
Hybrid Justice: The Extraordinary
Chambers in the Courts of Cambodia
(University of Michigan Press, 2014),
433 pages, ISBN 978-0-472-12021-5
(e-book)

I. INTRODUCTION

This title is published in the University of Michigan Press series "Law, Meaning, and Violence." John D. Ciorciari and Anne Heindel are lawyers who are well-positioned to write about the Extraordinary Chambers in the Courts of Cambodia, a special court set up by Cambodia and the United Nations, to try senior figures of the former Khmer Rouge government of Cambodia.

Ciorciari and Heindel both have extensive experience in Cambodia as advisors to the Documentation Center of Cambodia, which collects data on human rights violations committed in Cambodia during the period of Khmer Rouge rule, 1975 to 1979. Both authors have written extensively on legal and contextual aspects of the work of the Chambers.

The Chambers are established as a court of Cambodia, but with international participation and a mandate to prosecute not only under Cambodian penal law, but for internationally defined offenses. The Chambers' jurisdiction is limited to prosecuting senior Khmer Rouge figures only, and only for acts dating from the period of Khmer Rouge rule. The authors' focus, as the title suggests, is the character of the Chambers as "hybrid." At all key levels, personnel from inside and outside Cambodia share functions. They are appointed by a Cambodian institution that oversees judicial appointments, but