

THE INTERNATIONAL RIGHT TO HEALTH CARE: A LEGAL AND MORAL DEFENSE

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INTRODUCTION

Scholars, politicians, and the general public alike continue to debate the existence of moral rights to health or health care ('health rights')¹ and whether domestic laws should acknowledge such rights. Yet international human rights law clearly recognizes a right to health. As Stephen P. Marks notes, "[e]very country in the world has accepted that human rights are universal and is bound by at least one treaty containing a provision on the right to health."² The scope and nature of this right is contested, but the existence of the right as a matter of positive international human rights law is not.³ Given this, one may think that debate about the status of the right to health care in international human rights law is a non-starter. Once one recognizes that realizing a right to health requires health care guarantees, recognition of the international right to health care as part of the recognized international right to health should easily follow. Where fully realizing a right to health is likely impossible, one could further think that focusing on

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1. The line between health care and other health-related goods is not always clear. Any definition of health care will likely admit of borderline cases. I operate here on the assumption that we can identify certain paradigmatic/core cases of health care. In my doctoral dissertation, I adopt a working definition of "health care" as "curative, diagnostic and preventative goods and services provided by (preferably licensed) medical, dental, allied health, and psychological professionals qua professionals." Michael Da Silva, *Realizing the Right to Health Care in Canada* (2018) (unpublished doctoral dissertation, University of Toronto) (on file with author). This definition is imperfect (e.g., it relies on professional practice, which introduces a threat of circularity or too much deference to expertise), but is functionally useful here.

2. Stephen P. Marks, *The Emergence and Scope of the Human Right to Health*, in *ADVANCING THE HUMAN RIGHT TO HEALTH* 3, 20 (José M. Zuniga et al. eds., 2013). While new states have been recognized since 2013, the general point about ubiquity remains.

3. See generally Marks, *supra* note 2.

specific goods and services, including health care goods and services, is the only way to realistically measure realization of the right to health.⁴ From this point of view, it may seem obvious that the international right to health includes a right to health care as one of its constituent parts. Yet recognition of an international right to health care remains contentious. While the nature of the debate on the existence of an international right to health care differs from many domestic debates about health rights, a good case against the existence of an international right to health care can be and has been made even from a progressive, pro-rights perspective.

In the following, I outline the case against the international right to health care and explain why recognition of such a right is still necessary. The argument is explicitly limited to international human rights law and is primarily descriptive in nature, but I go on to explain the moral reasons to accept this account. Both the positive law and moral reasoning could be used in other health rights debates, but I do not attempt to make such claims here.

The structure of my work is as follows. I first outline three problems with recognizing an international right to health care. Then, I present a defense of the right. My defense takes the form of two lines of argument. First, I argue that the plain text of the documents that create and interpret the right to health supports the idea of a right to health care. Contrary to critics' claims, the relevant provisions often highlight the importance of particular health care goods and services and create specific obligations for states to provide them. The provisions explaining these requirements are tied not only to a concern with improved health outcomes, but also to other foundational norms of international human rights law, such as dignity and equality, which require provision of basic health care and fair distribution of all health care resources. In the alternative, I argue that, even if the international right to health does not obviously include a right to health care as a matter of textual interpretation, such a right can be and should be developed from other international rights that share the right to health care's foundational concerns with dignity and equality. As part of this alternative approach, I further argue that international law more broadly prioritizes health care and that recognition of an international right to health care is a good way of rendering international law coherent by emphasizing health care's priority in another area of law. Following presentation of these arguments, I outline the moral value of recognizing an international right to health care, explain how my arguments resolve three problems with recognizing such a right, and address a set of lingering objections.

4. See, e.g., *infra* pp. 38–39 on impossibility claims. But see Amartya Sen, *Elements of a Theory of Human Rights*, 32 PHIL. & PUB. AFF. 315, 348 (2004) for a contrary view on the feasibility point.

I. THREE PROBLEMS FACING AN INTERNATIONAL RIGHT TO HEALTH CARE

The existence of a right to health is uncontested as a matter of positive international human rights law. The International Covenant on Economic, Social and Cultural Rights' (the "ICESCR") canonical definition of this 'international right to health' guarantees "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."⁵ It can be difficult to determine how to parse this phrasing. For instance, one can argue over whether the "highest attainable standard" should be set at a population level (viz., duty-bearers must ensure that all people reach a shared standard all persons should reach) or at an individual level (viz., duty-bearers must ensure that all people reach the highest standard that it is possible for the individual persons to reach).⁶ Yet it is reasonably clear that any individual-focused view is going to require the standard to be tailored to individual circumstances rather than giving each person a right to the highest level of well-being they could possibly have; no one has a 'right' to be Superman and the state is under no duty to create superpeople as part of a social contract. It is also clear that the right cannot require all persons to reach the same level of well-being. Factors beyond the control of any persons will ensure some disparities. Finally, it is clear that, if the standard is set at a population level, the standard cannot be full health. Some people are going to be unhealthy. Almost all persons will be unhealthy by common standards at some point in their lives if they follow the regular human life cycle.

The Committee on Economic, Social and Cultural Rights' (the "CESCR") authoritative interpretation of the ICESCR, General Comment 14: The Right to the Highest Attainable Standard of Health (the "GC 14") accordingly clarifies that the right "is not to be understood as a right to be healthy."⁷ It is instead a set of freedoms and entitlements to goods and

5. International Covenant on Economic, Social and Cultural Rights art. 12, *opened for signature* Dec. 16, 1966, 993 U.N.T.S. 3 [hereinafter ICESCR]. Similar phrasing appears in Convention on the Rights of the Child art. 24, ¶ 1, *opened for signature* Nov. 20, 1989, 1577 U.N.T.S. 3 [hereinafter CRC]; G.A. Res. 48/104, Declaration on the Elimination of Violence against Women, art. 3(f) (Dec. 20, 1993) [hereinafter DEVW]; Convention on the Rights of Persons with Disabilities art. 25; *opened for signature* Mar. 30, 2007, 2515 U.N.T.S. 3 [hereinafter CRPD].

6. ICESCR, *supra* note 5, art. 12.

7. Comm. on Econ., Soc. & Cultural Rts., General Comment No. 14: The Right to the Highest Attainable Standard of Health, ¶ 8, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) (emphasis in original omitted) [hereinafter GC 14].

I identify the content of the right to health and thus my proposed right to health care by examining treaties, customary international law, and general principles of law that discuss health, authoritative interpretations thereof, and documents mentioned in those interpretations. In so doing, I use non-binding international legal documents as sources of international law scholarship and guides to the content of the positive law. While one could argue that these are subsidiary sources and thus recognized sources of law per the terms in the Statute of the

services,⁸ namely those that are “necessary for the realization of the highest attainable standard of health.”⁹ More precisely, it “must be understood as a right to the enjoyment of a variety of facilities, goods, services, and conditions necessary for the realization of the highest attainable standard of health.”¹⁰ Given resource constraints, it is likely the case that even this narrower understanding of a right to health cannot be fulfilled by any candidate duty-bearer. Controversies as to whether it makes sense to discuss a right to health as a matter of morality thus persist. It is unclear whether a right to health can fit the model of all rights having correlative duties (the ‘claim-right model’).¹¹ Yet international human rights law does not always require rights to be fully realizable to be recognized as legal entitlements. Indeed, it recognizes the problem of resource constraints and thus only requires immediate realization of a minimum core of social, cultural, and

International Court of Justice art. 38, *opened for signature* June 26, 1945, 3 U.S.T. 1153, the following argument should be legally persuasive, even if one simply grants that non-binding declarations are valid international law documents in the absence of compliance and that authoritative interpretations of binding documents are evidence of how best to interpret them. See Da Silva, *Realizing the Right to Health Care in Canada*, *supra* note 1 for more detail on how I limit my sources of analysis.

The argument should, moreover, be normatively persuasive if one gives any value to these non-binding documents. Insofar as state practice determines how we should understand international rights, the fact that a majority of states recognize constitutional rights to health care provides some support for the view that states believe they are bound to fulfill an international right to health care. See PATRICK MACKLEM, *THE SOVEREIGNTY OF HUMAN RIGHTS* 63–64 (2015) on the general ‘internal’ normativity of human rights. The differing structures between constitutional rights across the world and between constitutional rights and the international right features in authoritative interpretations provides reason to question this view. But see Lisa Forman et al., *Conceptualising Minimum Core Obligations under the Right to Health: How Should We Define and Implement the ‘Morality of the Depths,’* 20 INT’L J. HUM. RTS. 531 (2016) for possible convergence. My argument is not fundamentally based on state practice. But it does suggest that reading the right to health as entailing a right to health care makes international law better cohere with transnational norms, which could be read as a state practice argument.

8. Henceforth, ‘goods’ should be read as encapsulating ‘goods and services’ absent indications to the contrary.

9. GC 14, *supra* note 7, ¶ 9.

10. *Id.*

11. For that model, see Wesley Newcomb Hohfeld, *Some Fundamental Legal Conceptions as Applied in Judicial Reasoning*, 23 YALE L.J. 16 (1913); Wesley Newcomb Hohfeld, *Fundamental Legal Conceptions as Applied in Judicial Reasoning*, 26 YALE L.J. 710 (1917). For the standard status of this model, see, for example, Hugh Upton, *Right-Based Morality and Hohfeld’s Relations*, 4 J. ETHICS 237 (2000). For the criticism that health rights cannot fit the model, which would actually undermine the broader right to health too, see, for example, Gopal Sreenivasan, *A Human Right to Health? Some Inconclusive Scepticism*, 86 ARISTOTELIAN SOC’Y SUPPLEMENTARY VOLUME 239 (2012).

economic rights (including the right to health) and progressive realization of the other elements of the rights.¹²

While even the international right to health may not fit the traditional claim-right model of rights, the international right still exists and has a structure that allows one to measure its realization. It is a right to goods necessary for attaining the highest attainable level of health. Realization of the minimum core of the right should ensure that all people meet some standard, which may not be the highest one attainable. Progressive realization should eventually bring all people to the highest standard attainable since that is the required content of the right.¹³ We can then measure how nations provide the necessary goods. But these goods are instrumental to an outcome. We can thus also study the extent to which providing these goods meets the ultimate desired outcome, namely ensuring *all* persons reach this highest attainable standard of well-being. In each case, we are interested in maximizing the number of individuals who meet each standard, suggesting that the population-focused interpretation of the right is ultimately more consonant with the ICESCR's canonical definition.¹⁴

Based on the canonical definition and its attendant framework, it may seem obvious that the international right to health includes a right to health care as one of its constituent parts. Surely health care goods are necessary for realization of the highest attainable standard of health! Even GC 14 skips this explanation, assuming that readers will understand that there is a right to health care as part of the non-justiciable right to health and going on to explain that the right to health *also* includes rights to social determinants of health.¹⁵ The existence of the international right to health care is assumed to be so obvious that only the international right to the social determinants of health requires explanation.

12. Comm. on Econ., Soc. & Cultural Rts., General Comment No. 3: The Nature of States Parties' Obligations, ¶ 1, U.N. Doc. E/1991/23 (Dec. 14, 1990) [hereinafter GC 3]; GC 14, *supra* note 7, ¶¶ 30, 43–45.

13. See ICESCR, *supra* note 5, art. 12; GC 14, *supra* note 7, ¶ 9.

14. This point is further reinforced by the emphasis on social determinants of health discussed below.

15. GC 14, *supra* note 7, ¶ 4. Social determinants of health can be understood as causal contributors to health. Social determinants of health are legion and include safe and healthy working conditions, a healthy environment, and housing. On this broad definition, health care qualifies as a social determinant. For present purposes, I understand the social determinant as the non-health care-related components of the right. As noted below, *infra* note 25, international human rights law recognizes the social determinants as being distinct from health care. So, my distinction here is necessary to explain the relevant legal phenomena. Barbara Wilson, *Social Determinants of Health from a Rights-Based Perspective*, in REALIZING THE RIGHT TO HEALTH 60, 62 (Andrew Clapham et al. eds., 2009) provides a longer list of social determinants and a discussion of their status in international human rights law. Her text is also an example of scholarly use of the social determinants/health care distinction I use here.

Proponents of an international right to health care nonetheless face at least three difficulties that jointly present a strong case against recognition of such a right. They must address these difficulties if they are going to justify and persuasively advocate for the international right to health care.

A. International Human Rights Law Focuses on Social Determinants

First, while the legal documents granting and specifying the content of the right to health refer to health care goods and services, the majority of the right's attendant duties relate to the social determinants of health. After its canonical definition, the second sub-clause of the ICESCR's articulation of the right to health goes on to state that:

The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

- (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
- (b) The improvement of all aspects of environmental and industrial hygiene;
- (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
- (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.¹⁶

Condition (d) is related to health care. Conditions (a) and (c) may require some health care provision. Yet (a) and (c) also require provision of the social determinants of health, and (b) is only related to social determinants. Duties to provide all four apparently only exist insofar as they are instrumental to fulfilling a greater duty to realize health and, as the second problem below makes clear, (d) may be least effective in fulfilling this instrumental role and thus lowest priority in this list.

This list is, moreover, non-exhaustive. Other documents highlight the importance of the social determinants of health even more explicitly. The authoritative interpretation of the right to health explicitly states that food and shelter form part of the non-derogable core obligations states must provide regardless of resource constraints.¹⁷ While it also states that

16. ICESCR, *supra* note 5, art. 12, ¶ 2.

17. GC 14, *supra* note 7, ¶ 43. I am skeptical of the conceptual coherence of core obligations as articulated in GC 14 for reasons like those in Katharine G. Young, *The Minimum Core of Economic and Social Rights: A Concept in Search of Content*, 33 YALE J. INT'L L. 113 (2008). Authoritative interpretations of positive international human rights law nonetheless recognize minimum core obligations. GC 14 is one such example. It discusses "core obligations" from ¶¶ 43–45. For more on minimal core content and a list of other

realization requires “functioning public health and health-care facilities, goods and services,” the list of facilities, goods, and services that fall under this banner primarily focuses on social determinants.¹⁸ Only one class of traditional health care goods is listed:

The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party’s developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO [World Health Organization] Action Programme on Essential Drugs[.]¹⁹

While there are also passages suggesting that the right entails a right to maternal and infant care, the passage in GC 14 is conditional: the goal is to reduce maternal mortality and stillbirth, and this goal “may be understood” as requiring certain forms of health care.²⁰ It is plausible to think that it may be so understood only when those forms of health care actually contribute to such outcomes. Other bodies addressing similar concerns under the right to health also emphasize the need to realize social determinants of health. For instance, the Committee on the Elimination of Discrimination Against Women calls on States to provide “timely access” to family planning services,²¹ which may not easily fit under the health care umbrella. General Assembly resolutions and political declarations alike commonly stress the importance of social determinants.²²

Even international human rights law documents that highlight the importance of health care often end up collapsing the distinction between health care and social determinants of health in a way that supports reading the right to health as fundamentally concerned with the social determinants.²³ For instance, Steven D. Jamar describes the “international

references to the term in authoritative interpretations of international law, see, e.g., Forman et al., *supra* note 7.

18. GC 14, *supra* note 7, ¶ 12.

19. *Id.*

20. *Id.* at ¶ 14.

21. Comm. on the Elimination of Discrimination Against Women, Rep. on the Work of Its Twentieth and Twenty-First Sessions U.N. Doc. A/54/38/Rev.1, at 7 (1999).

22. See, e.g., G.A. Res. 63/33, Global Health and Foreign Policy (Dec. 6, 2012) [hereinafter Global Health]; World Health Org. [WHO], *Rio Political Declaration on Social Determinants of Health*, in World Conference on the Social Determinants of Health, *Meeting Report*, annex A, at 48 (Oct. 21, 2011), http://www.who.int/sdhconference/resources/Conference_Report.pdf (last visited Oct. 4, 2018).

23. For present purposes, the sources of international law include international agreements, customary international law, general principles of law, and subsidiary sources, including authoritative interpretations of the first three sources and expert scholarly work and

sense” of health care as including “at least public health, sanitation, occupational and environmental conditions, education and nutrition, as well as medical treatment.”²⁴ This is an error. International human rights law recognizes sanitation et al., as social determinants of health and distinguishes them from health care.²⁵ But Jamar’s error is an easy one to make. The documents outlining the international right to health do not prioritize traditional medicinal or even public health goods that most commonly fit under the label of ‘health care.’ Rather, they recognize a variety of social determinants of health as key to realizing the right to health.

Insofar as one is partial to recognizing an international right to health care, it is natural to adopt a broader definition of health care that includes these social determinants. International human rights law even collapses the distinction at times. For instance, both the Declaration of Alma-Ata and the WHO’s specific examples of what is included in primary health care include social determinants like education and water,²⁶ blurring the line between health care and social determinants and supporting Jamar. Yet GC 14, for one, recognizes the social determinants of health as distinct from health care.²⁷ The Constitution of the WHO, in turn, explicitly states that governments must provide “adequate health and social measures.”²⁸ This conjunction suggests that health measures and social measures are distinct, and each is recognized as a necessary government means to fulfill an end of improved health. International human rights law more broadly, then, distinguishes health care and the social determinants of health. But even text supporting the right to health care can be read as actually supporting a broader set of goods, primarily consisting of social determinants.

Passages of international human rights law emphasizing the interconnectedness of all rights likewise provide a textual case against the international right to health care. International human rights law states that all human rights are “indivisible.”²⁹ Many social determinants of health,

reports on same; Statute of the International Court of Justice, *supra* note 7, art. 38. While I am aware of the debates about the sources of international law, untangling the issues in those debates is orthogonal to the present task (particularly given my focus on positive international law as it currently exists).

24. Steven D. Jamar, *The International Human Right to Health*, 22 S.U. L. REV. 1, 4–5 (1994).

25. See, e.g., GC 14, *supra* note 7, ¶ 9.

26. Int’l Conf. on Primary Health Care, *Declaration of Alma-Ata*, art. VII, U.N. Doc. CF/HST/1985-034/Anx.04/07 (Sept. 12, 1978) [hereinafter *Declaration of Alma-Ata*]; Jamar, *supra* note 24, at 47; GC 14, *supra* note 7, ¶¶ 43–44.

27. GC 14, *supra* note 7, ¶ 4.

28. Const. of the WHO, pmbi., 14 U.N.T.S. 185 (July 22, 1946).

29. The first major statement of this indivisibility is the Int’l Conf. on Hum. Rts., *Proclamation of Teheran*, U.N. Doc. A/CONF.32/41 (May 13, 1968) (see especially ¶ 13). The indivisibility was further established by more authoritative and binding statements of international human rights law. It is now even included in arguable boilerplate in the

including education and water, are also standalone international rights.³⁰ Where rights are indivisible as a matter of positive international human rights law, recognition of a right in one international human rights law document is evidence of its existence as a component of another right. Such evidence is lacking in the case of the right to health care. There is no standalone right to health care outside of the passages articulating the right to health (and/or passages articulating other related, explicitly recognized rights).

Arguments for health justice outside of international law similarly highlight the importance of social determinants of health in a way that could impact the persuasiveness and value of any right to health care in international law. Jennifer Prah Ruger, for one, suggests that health functioning and agency, which require more than just health care provision, should be the focus of our moral deliberations and that access to health care is valuable only to the extent that it promotes functioning and agency.³¹ Per Ruger, governments accordingly ought to provide “the social conditions in which all individuals have the capability to be healthy” as a matter of justice.³² Even if one brackets Ruger’s broader commitments to functioning and agency and focuses just on being healthy, such conditions are clearly broader than access to health care, partly for reasons described below. Health care itself is not a “social condition,” and “living in a nation with a functioning health care system” is only one of many conditions that create this capability. Even traditional champions of health care justice, like Norman Daniels, now emphasize the importance of the social determinants of health for distributive justice more generally.³³ Insofar as secondary sources are authorities in international human rights law,³⁴ the fact that moral arguments for health rights focus on social determinants can be taken as evidence against the existence of an international right to health.³⁵ This

beginning of human rights documents. *See, e.g.*, G.A. Res. 64/292, The Human Right to Water and Sanitation (Aug. 3, 2010). For good critical analysis of the indivisibility of human rights, including some history, see, for example, MACKLEM, *supra* note 7, at 63–64; DANIEL J. WHELAN, *INDIVISIBLE HUMAN RIGHTS: A HISTORY* (2010); James W. Nickel, *Rethinking Indivisibility: Towards a Theory of Supporting Relations Between Human Rights*, 30 Hum. Rts. Q. 984 (2008).

30. The right to education is featured in ICESCR, *supra* note 5, arts. 13–14. For the documents outlining the international right to water, see, for example, Hum. Rts. Council, Rep. of the United Nations High Comm’r for Hum. Rts. on the Scope and Content of the Relevant Hum. Rts. Obligations Related to Equitable Access to Safe Drinking Water and Sanitation Under Int’l Hum. Rts. Instruments, U.N. Doc. A/HRC/6/3 (2007).

31. JENNIFER PRAH RUGER, *HEALTH AND SOCIAL JUSTICE* 36, 134 (2009).

32. *Id.* at 134.

33. NORMAN DANIELS, *JUST HEALTH: MEETING HEALTH NEEDS FAIRLY* (2008).

34. Statute of the International Court of Justice, *supra* note 7, art. 38.

35. International human rights law-specific arguments prioritizing the social determinants of health like Jamar, *supra* note 24, arguably have an even stronger claim to be sources of international law. I do not repeat my discussion of such sources here, but the fact

suggests that any international right to health care will have limited scope at best.

B. *Increased Access to Health Care Does Not (Maximally) Correlate with the Normative Goals of the Right to Health*

Where Ruger (like Daniels) discusses health justice rather than international human rights law, her claims may be even more persuasive evidence for the second challenge facing the purported international right to health care.³⁶ In short, second, the normativity of the international right to health is tied to the importance of certain benchmarks and indicators of health across populations, but recognition of health rights and access to health care do not strongly correlate with improved health outcomes (at least when compared to many social determinants). This suggests that the normativity of the international right to health may not justify an international right to health care.

The textual problem above already highlights the fact that seeming international rights to health care appear to exist only as they are instrumental to realization of the right to health. Yet health care does not appear to be a strong causal factor in achieving good health, at least when compared with many social determinants of health. The purely instrumental rights to health care goods will be severely limited if they cannot fulfill their instrumental aims. Scientific and social scientific data suggests that they are (at minimum comparatively) weak contributors to good health. Daniel Callahan outlines this general point well:

It has long been known that it is not high technology, cure-oriented medicine that best promotes population health. Instead, public health measures and socioeconomic improvement accounted for most of the reduction of mortality over the past century. That knowledge should lead to an obvious conclusion: goals and priorities oriented to population health should, in general, have the highest place in health care, in research, and in health policy.³⁷

This is not statistical data. Moreover, even Callahan thinks that more things matter than just mortality. He identifies several goals of health care in a form of non-rights-based value pluralism.³⁸ Yet Callahan's charge against the causal role of medicine in good health undermines the potential for any purported right to medicinal health care.

that international human rights law scholars emphasize the importance of the social determinants can also play a role in this prong of the case against the international right to health care.

36. See RUGER, *supra* note 31. For Daniels, see *supra* note 33.

37. Daniel Callahan, *Ends and Means: The Goals of Health Care*, in *ETHICAL DIMENSIONS OF HEALTH POLICY* 3, 15 (Marion Danis et al. eds., 2002).

38. See generally *id.*

Even if, like Callahan,³⁹ one includes public health as part of health care, it is clear that many other social determinants are even more important than health care. Articles in a special issue of *Perspectives in Biology and Medicine*, an interdisciplinary health journal, outlined several good examples. For example, one's place in the social status appears to substantially impact health. The "social gradient" is common throughout the world and across populations.⁴⁰ It is unclear if and how health care contributes to these and other inequities.⁴¹ Increased "physiological capital," the physical capacity to perform certain tasks, similarly has historically had a greater impact on reducing health inequalities than has increased access to health care.⁴² This is primarily because it reduces "socioeconomic disparities in the burden of disease."⁴³ According to Robert W. Fogel, this supports the view that "environmental improvement is more important than access to health care."⁴⁴ Other significant factors affecting one's health include one's neighborhood⁴⁵ and social isolation.⁴⁶ Access to medicine correlates less strongly with improved health. Public health initiatives may correlate somewhat better, but other social determinants appear even more important to realizing the highest attainable standard of health.

The obvious response to this second problem is to state that, even if it is true that other factors better correlate with improved health, it is wrong to ignore the impact that health care, particularly public health but even medicine, has on health outcomes. Health care, in other words, is

39. Per Callahan: "Medicine is the historically prior institution, and its goals in practice determined for many centuries what health care became available . . . With the advent of a public health perspective much later, and then of organized social and political systems designed to improve health by deploying both medicine and public health, it became possible to speak of health care as the generic category for all efforts, medical or otherwise, to protect and foster good health. Nonetheless, even if medicine can now be subsumed under the broader category of health care, its scientific knowledge and ability to determine . . . the biological pathways of disease give it a central role in health care. Medicine remains the fundamental discipline of health care." *Id.* at 6.

He notes that the distinctions between medicine and public health do not create "anything close to air-tight compartments. Like all typologies, this one [distinguishing the two and their respective goals] is meant to put the world into some kind of order; and the world, as always, is not nearly so accommodating as are our invented categories." *Id.* at 8.

40. Michael G. Marmot, *Understanding Social Inequalities in Health*, 46 *PERSP. BIOLOGY & MED.* S9, S9 (2003).

41. *Id.* at S14–S15.

42. Robert W. Fogel, *Secular Trends in Physiological Capital: Implications for Equity in Health Care*, 46 *PERSP. BIOLOGY & MED.* S24, S24 (2003).

43. *Id.* at S28.

44. *Id.* at S32–S33.

45. Robert J. Sampson, *The Neighbourhood Context of Well-Being*, 46 *PERSP. BIOLOGY & MED.* S53 (2003).

46. John T. Cacioppo & Louise C. Hawkey, *Social Isolation and Health, with an Emphasis on Underlying Mechanisms*, 46 *PERSP. BIOLOGY & MED.* S39 (2003).

instrumentally valuable for health in absolute terms, even if it is not comparatively instrumentally valuable. Charles Kenny provides one of the best statistical arguments that human rights and development programs have been instrumental to improving mortality and other health outcomes throughout the world. He stresses that social determinants of health are among the most important contributors to these improvements, but he also states that increased access to vaccines played a foundational role.⁴⁷ Callahan's challenge, in turn, was lodged against the backdrop of traditional biases toward individual health care.⁴⁸ He worried that rising health care costs, in particular in the pharmaceutical domain, were tied to this emphasis on the individual.⁴⁹ Yet he too ultimately recognized the continued importance of health care even as he called for increased emphasis on the social determinants of health:

A final motivation for a reexamination of the goals of health care would be to take better account of the increasing knowledge of the socioeconomic determinants of health. As matters now stand, medical treatments and cures are sought for many health conditions that might be greatly reduced by such nonmedical strategies as improvements in education, employment, and the environment. The traditional medical goal of treating the sick would remain, but a great emphasis would fall not only on public health but also on improving those social conditions known to affect health.⁵⁰

Elsewhere, he states that social determinants demand a "role in health policy, even though they are outside health care systems as customarily understood,"⁵¹ which is consistent with seeing them as distinct means of trying to achieve the same end.

Other scholars mentioned above have likewise seemed to recognize some value in health care. Proponents of community-wide interventions to address neighborhood-related issues recognize that those can complement individually-focused policies (though some do not go as far as to say that health care provision programs will do so).⁵² Much of Fogel's data focuses on curative medicine as being equivalent to health care, but certain forms of

47. CHARLES KENNY, GETTING BETTER: WHY GLOBAL DEVELOPMENT IS SUCCEEDING—AND HOW WE CAN IMPROVE THE WORLD EVEN MORE (2011).

48. Callahan, *supra* note 37, at 15, identifies this bias in the American context in the context of his argument for greater emphasis on the social determinants of health.

49. *Id.* at 16–17.

50. *Id.* at 8. Callahan actually links my critique of Jamar and Ruger's concerns. He states that, even if one rightly recognizes that socioeconomic conditions "should surely enter into any broad scheme of health care," one can more narrowly define health care, focusing primarily, in the ordinary cases that motivate the bulk of health law and policy, on public health and medicine. *Id.* at 4; see also *id.* at 8, 13.

51. *Id.* at 6.

52. Sampson, *supra* note 45, at S61–S62.

neonatal care that he emphasizes as important are plausibly understood as health care.⁵³ So, even Fogel seems to recognize the import of some kinds of health care. He also ultimately acknowledges that health care outreach programs are important (though primarily because they can help out with environmental factors). Finally, social isolation too has a significant impact on health.⁵⁴ There are indications that capitalism itself partly contributes to increased social isolation.⁵⁵ Few would warrant reordering the social structure for this alone, particularly given that the right to health is supposed to be consistent with all forms of government. But even proponents of drastic changes, such as the end of capitalism, recognize that preventative medicine and palliative care would be helpful incremental improvements.⁵⁶ Everyone seems to agree that providing some health care can have positive outcomes. An argument from authority can thus help address this second concern.

Even leaving these authorities aside, moreover, comparative analysis of the relative contributions of health care and social determinants of health to health outcomes does not undermine the claim that a right to health care is valuable. The easy response to the second challenge, then, is just to grant weak correlation between health care and health outcomes (at least when compared to the correlative between the social determinants of health and health outcomes) and state that some correlation is all that is necessary. The right to health care here will be as limited as the causal connections between health and health care, but it will still exist.

There is, however, a version of this argument that is more damning for proponents of the right to health care. Much of the concern here appears to be that recognizing a right to health care will lead to poor priorities. This is an international equivalent of the concerns that domestic constitutional rights are too easily “co-opted.”⁵⁷ Much of the data supporting the primacy of the social determinants of health is comparative in nature.⁵⁸ If the forgoing is true, the data does not prove that there cannot or should not be a right to health care when looked at in isolation. Yet recognition of a right to health care can lead to outsized spending on expensive health care goods. Actual recognition of such rights in the domestic sphere often leads to increased health care for middle class individuals and does not improve the health of the worst-off members of society.⁵⁹ Too many people accordingly

53. E.g., Fogel, *supra* note 42, at S34.

54. Cacioppo & Hawkley, *supra* note 46.

55. *Id.* at S50.

56. *Id.* at S50–S51.

57. See the sources in note 59 below.

58. See, for instance, notes 52–54 and the surrounding text.

59. For example, this appears to be true in Brazil. Armando De Negri Filho, *Brazil: A Long Journey Towards a Universal Healthcare System*, in *ADVANCING THE HUMAN RIGHT TO HEALTH*, *supra* note 2, at 176; Octavio Luiz Motta Ferraz, *The Right to Health in the Courts of Brazil: Worsening Health Inequities?*, 11 *HEALTH & HUM. RTS.*, 33 (2009); Virgilio

remain below the internationally guaranteed standard of health, while others access goods needed to reach a higher level. Talking about an international right to health care, even as a component of a broader right to health, may thus confuse the public into thinking they have expansive health care entitlements under international law and that governments must spend a great deal on more expensive goods. This could lead to less funding for the social determinants of health that actually correlate well with increased health.

One should, on this view, thus only talk of a right to health. Any claimed entitlements to health care goods should be explicitly discussed in terms of their proven impact on achieving the internationally guaranteed standard of health. Determining whether they are actually entitlements as part of the right should include a comparative analysis to see if the right would be better achieved by other social determinants to avoid misplaced priorities that do not accord with the normative goal of increased well-being. Such comparative analysis will often auger in favor of the social determinants of health. The health care component of the international right to health will thus be limited. It will include vaccines, given Kenny's aforementioned data,⁶⁰ but the remaining scope of the right will be limited. It will also be difficult to identify *ex ante*, undermining the action-guiding nature of an international right to health care. If the scope of the right is only determinable in comparative contextual analyses, there will be little room to identify the scope of any purported right to health care as a component of the right to health simply by reading the relevant international documents outside of particular contexts where particular funding decisions need to be made. Explicitly setting out the content of the right in legislation will be impossible since the scope will always be context-dependent. Current provisions requiring specific goods will lack justification since many of the health care goods guaranteed under international human rights law do not contribute to improved health more than the social determinants.⁶¹ This version of the second problem cannot be solved by just pointing to the fact that some health care goods do improve health, even if no one disagrees with that claim.

C. *The Purported International Right to Health Care Does Not Fit the Structure of International Human Rights*

Finally, very few international rights require states to create full systems to realize rights, and international human rights law that supports a

Alfonso da Silva & Fernanda Vargas Terrazas, *Claiming the Right to Health in Brazilian Courts: The Exclusion of the Already Excluded?*, 36 L. & SOC. INQUIRY 825 (2011). *But see* César Rodríguez-Garavito, *Beyond the Courtroom: The Impact of Judicial Activism on Socioeconomic Rights in Latin America*, 89 TEX. L.R. 1669 (2011).

60. Kenny, *supra* note 47.

61. *See infra* pp. 18–21 for examples of these goods.

right to health care seems to require states to create health care systems. This presents a mismatch between the purported international right to health care and the structure of international human rights generally.

International human rights law contains a requirement for a functioning health care system as part of the right to health.⁶² Other passages further express the need for both a functioning health care system and a legal framework that defends it. The entitlements in GC 14 “include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.”⁶³ While legislation is just one option among many for most social rights, the CESCR states that “[i]n fields such as health . . . legislation may also be an indispensable element for many purposes.”⁶⁴ Some statutory protection of the health care system seems necessary.⁶⁵ A further requirement for a *fair* system for health care allocation can be derived from international human rights law’s commitment to non-discrimination in decision-making. Per international human rights law, a fair process for identifying the rights to which one should be entitled must ensure that decisions are made free from discriminatory intent and do not have discriminatory effect. It must then ensure that whatever goods it selects are distributed in a method that ensures equality of opportunity. For example, the ICESCR’s references to the “equal and inalienable rights of all” and the rights of “everyone” are read as reflecting the foundational values of equality and non-discrimination.⁶⁶ This has implications for the structure of the selection process and its implementation. Whatever the result of the process in terms of the range of goods covered, persons must have equal opportunity to receive their fair share. A functioning health care system is needed to provide them.

Still, other passages require national policies and strategies for realizing the right. The Declaration of Alma-Ata states that “governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system.”⁶⁷ GC 14 takes this further and states that the obligation to fulfill the right to health includes a requirement to “give sufficient recognition to the right to health in the national political and legal systems, preferably by way

62. *Rio Declaration*, *supra* note 22, at 48, ¶ 7.

63. GC 14, *supra* note 7, ¶ 8.

64. GC 3, *supra* note 12, ¶ 3.

65. *See, e.g.*, Comm. on the Rts. of the Child, General Comment No. 15 (2013) on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health, ¶ 94, U.N. Doc. CRC/C/GC/15 (Apr. 17, 2013).

66. ICESCR, *supra* note 5, pmb.; Comm. on Econ., Soc. & Cultural Rts., General Comment No. 20: Non-Discrimination in Economic, Social and Cultural Rights, ¶ 3, U.N. Doc. E/C.12/GC/20 (July 2, 2009).

67. *Declaration of Alma-Ata*, *supra* note 26, art. VIII.

of legislative implementation, and to adopt a national health policy with a detailed plan for realizing the right to health.”⁶⁸

International human rights law, then, appears to require a system for distributing health care in a fair manner that is (preferably) legislatively-protected and a national policy for distributing health care. This is demanding and does not accord with the structure of other international rights. Other international human rights do not entail duties to establish systems of distribution or protection or national strategies or policies. Social, economic, and cultural rights uncontroversially entail obligations of conduct and result.⁶⁹ Such obligations require states to respect, protect, and fulfill the rights.⁷⁰ Fulfilling the rights will often require creating systems of rights protection and sometimes even systems of distribution. But the explicit requirement to create a formal system for distributing goods under the right to health is not a universal or even common feature of international human rights. The right to food, for instance, does not entail explicit duties to establish food distribution services.⁷¹ The right to education requires some education system to be realized, but it is not explicitly placed in the category of goods requiring legislative protection of a system that provides it. International human rights law is generally agnostic on how nations realize rights, partly due to its concern with ensuring that rights can be realized in a nation with any form of government.⁷² Other rights also tend not to require full *national* implementation policies.⁷³

The purported right to health care thus seems to fit uneasily with the structure of international rights. Stating that a broad right to health must include a narrower right to health care is an insufficient response to these concerns. If the narrow right actually demands more than other broad rights, this suggests a lack of fit between the narrow right and the broader rights that are clearly part of the order it seeks to join.

68. GC 14, *supra* note 7, ¶ 36.

69. GC 3, *supra* note 12, ¶ 1.

70. This point is widely recognized. *See, e.g.*, Daniel Tarantola, *Global Justice and Human Rights: Health and Human Rights in Practice*, 1 GLOBAL JUST. 11, 12 (2007); Scott Leckie & Anne Gallagher, *Introduction*, in ECONOMIC, SOCIAL, AND CULTURAL RIGHTS: A LEGAL RESOURCE GUIDE xx (Scott Leckie & Anne Gallagher, eds. 2006).

71. Comm. on Econ., Soc. & Cultural Rts., General Comment No. 12: The Right to Adequate Food, U.N. Doc. E/C.12/1999/5 (May 12, 1999) [hereinafter Food GC].

72. *E.g.*, GC 3, *supra* note 12, ¶ 8; Comm. on Econ., Soc. & Cultural Rts., General Comment No. 9: The Domestic Application of the Covenant, ¶ 5, U.N. Doc. E/C.12/1998/24 (Dec. 3, 1998).

73. Indeed, international human rights law's purported consistency with federalism and general agnosticism about forms of government is directly opposed to federal intervention requirements. For application of this agnosticism in the ICESCR context, see GC 3, *supra* note 12, ¶ 8 and Comm. on Econ., Soc. and Cultural Rights, General Comment 9: The Domestic Application of the Covenant, ¶ 5, UN Doc E/C.12/1998/24 (1998) [hereinafter GC 9].

D. Conclusion

The problems facing the international right to health care, then, are clear. But I believe they are surmountable. In this work, I accordingly defend the international right to health care on textual and theoretical grounds. If successful, this defense will address all three of these issues with existing accounts.

II. THE TEXTUAL ARGUMENT

The first two problems facing the international right to health care have textual origins. The text of positive international human rights law highlights the importance of social determinants of health and establishes a normative goal for the right to health that is best achieved by ensuring the social determinants of health rather than health care.

Luckily for proponents of the international right to health care, a more expansive survey of the relevant international human rights law documents provides a defense against both criticisms. The plain text of the documents that create and interpret the right to health supports the idea of a right to health care as one of its components. Contrary to social determinants-focused critics' claims, the relevant provisions often highlight the importance of particular health care goods and create specific obligations for states to provide those goods that cannot be reduced to purely functional commitments to goods that maximize health outcomes.

The statements from the ICESCR and the Declaration of Alma-Ata and interpretations thereof do not exhaust the statements on the scope of the right to health. Many other passages in international human rights law also articulate health care entitlements as part of the right to health. The Declaration of Alma-Ata is itself focused on primary health care. It actually followed a conference explicitly devoted to that topic. It states that a

main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.⁷⁴

The global community failed to meet this goal, but the Declaration's commitment to primary health care in setting that goal should not be ignored. Primary health care is central throughout international human rights law.⁷⁵ Providing "essential" primary health care is one of the first

74. *Declaration of Alma-Ata*, *supra* note 26, art. V.

75. Fellow right to health care proponent David Beetham suggests that agreement on primary health care is also part of a consensus among economists and human rights theorists

minimum core obligations under the ICESCR's right to health.⁷⁶ Primary health care provision is also listed as a core obligation under the child's right to health.⁷⁷

Moving beyond primary health care, other documents, including the earliest modern human rights documents, also emphasize the role of health care, including medicinal health care, as components of the international right to health. The earliest modern international human rights law document, the Universal Declaration of Human Rights (the "UDHR"), includes a right to "a standard of living adequate for the health and well-being of himself and of his family, including . . . medical care."⁷⁸ Provision of essential medicines is, in turn, prioritized in GC 14.⁷⁹ A right thereto can also be gleaned from section 15 of the ICESCR, which grants a right to benefit from scientific advances.⁸⁰ Still other statements of positive international human rights law explicitly list goods or types of goods that should be covered. GC 14 states that fulfilling the right requires "immunization programmes against the major infectious diseases."⁸¹ The Convention on the Elimination of Discrimination Against Women mentions "safeguarding of the function of reproduction" as part of its "right to protection of health" and states that parties "shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."⁸² While nutrition may be a social determinant of health, health care services are distinguishable from (or as) social determinants. The Convention on the Rights of the Child says parties must "take appropriate measures" to provide "necessary medical assistance and health care . . . with emphasis on the development of primary health care," "appropriate pre-natal and post-natal care for

about the minimal content of the right to health care; David Beetham, *What Future for Social and Economic Rights?*, 43 POL. STUD. 40 (1995).

76. GC 3, *supra* note 12, ¶ 10.

77. Comm. on the Rts. of the Child, *supra* note 65, ¶ 73.

78. G.A. Res. 217 (III) A, Universal Declaration of Human Rights, art. 25 (Dec. 10, 1948) [hereinafter UDHR].

79. GC 14, *supra* note 7, ¶ 17.

80. See Stephen P. Marks, *Access to Essential Medicines as a Component of the Right to Health*, in REALIZING THE RIGHT TO HEALTH, *supra* note 15, at 87. *But see id.* at 93 where he suggests the right is primarily "derivative" from rights to health and life. Marks suggests elsewhere that international intellectual property law may be at odds with international human rights law's commitment to essential medicines in some respects. See also Stephen P. Marks & Adriana L. Benedict, *Access to Medical Products, Vaccines, and Medical Technologies* in REALIZING THE RIGHT TO HEALTH 305. I address parts of this concern below. See *infra* Part III of this work for an argument that international trade law, including international intellectual property and patent law, actually highlights the importance of health care.

81. GC 14, *supra* note 7, ¶ 36.

82. Convention on the Elimination of All Forms of Discrimination Against Women, arts. 11–12, Dec. 18, 1979, 1249 U.N.T.S. 13 [hereinafter CEDAW].

mothers,” and “preventative health care.”⁸³ The Convention of the Rights of Persons with Disabilities states that parties “shall take all appropriate measures to ensure access . . . [to services] including health-related rehabilitation.”⁸⁴ Many international human rights law documents explicitly create entitlements to health care.

Even documents establishing the importance of the social determinants of health and outlining the social determinant-related content of the right to health highlight the importance of certain health care goods. For instance, United Nations General Assembly Resolution 63/33: Global Health and Foreign Policy lists universal health coverage as a determinant of health that must be considered when fulfilling the right to health, implicitly including health care as an important component of the right to health.⁸⁵ More explicitly, the WHO’s World Conference on the Social Determinants of Health repeatedly mentioned the importance of health care. Health care did not come up in every session of the conference, but it came up in multiple sessions.⁸⁶ The conference was also understood as building on the earlier health-care-focused conference at Alma-Ata, suggesting a continuity of interest between primary health care concerns and social determinants of health as aspects of the right to health care.⁸⁷ One of the five themes of the World Conference on the Social Determinants of Health was explicitly defined in terms of a need for “universal health care coverage that is accessible, affordable and of good quality” and the official explanation of the theme stated that health care services “are essential to the enjoyment” of the right to health.⁸⁸ The resulting Rio Declaration on the Social Determinants of Health in World Health accordingly pledged that signatories’ health care systems would “promote access to high-quality, promotive, preventative, curative and rehabilitative health services throughout the life cycle, with a particular focus on comprehensive and integrated primary health care.”⁸⁹

We must take the text of international human rights law at its word when it says that there are health care goods to which persons and groups are entitled under international human rights law. There is nothing to suggest that the health care goods listed in the relevant documents are more closely connected with health outcomes than are alternatives (vaccines notwithstanding). Simply limiting the list of goods required by international

83. CRC, *supra* note 5, art. 24, ¶¶ 2(b), (d), (f).

84. CRPD, *supra* note 5, art. 25.

85. Global Health, *supra* note 22.

86. WHO, World Conference on the Social Determinants of Health: *Summary Report* (2012) [hereinafter WHO, *Summary*]; *Rio Declaration*, *supra* note 22.

87. WHO, World Conference on the Social Determinants of Health, *Meeting Report: All for Equity* (2012), at ix; *Rio Declaration*, *supra* note 22, at 48, ¶ 3.

88. *Id.* at 50; WHO, *Summary*, *supra* note 86, at 3.

89. *Rio Declaration*, *supra* note 22, at 50.

human rights law to those that are proven to be instrumentally valuable for health will not explain the existing list of entitlements that the law recognizes, particularly if this instrumental value must be determined in comparison with social determinants of health as required by the second problem above. International human rights law promises a lot more than just vaccines.⁹⁰ Essential medicines, as articulated by the WHO for the purposes of international human rights law, include a wide variety of health care goods.⁹¹ Not all of them are goods for which improved access thereto strongly correlates with improved health, particularly across populations.

The best explanation for the continued recognition of, for instance, essential medicines as part of the textually supported health care component of the right to health is, I think, that these goods are highlighted for other reasons. These reasons may include realization of other international human rights, including equality rights, and commitments to the values underlying the international human rights law regime, such as dignity.

Dignity is the lynchpin of international human rights law. The first sentence of the UDHR begins with “recognition of the inherent dignity” of all persons, and dignity is again referred to in the fourth paragraph of the UDHR’s preface and in its first article.⁹² The importance of dignity is also recognized in nearly every relevant international human rights law document.⁹³ Other rights are explained as reflections of a broader commitment to dignity.⁹⁴ Curative medicine guarantees may not maximize health across populations or even maximize the number of persons at a level of well-being, particularly when contrasted with social determinant guarantees, but curative medicine is often necessary to restore people to the level of well-being necessary to live a dignified existence. This helps explain the essential medicine commitments above.

Equality and non-discrimination serve similar foundational roles in international human rights law. A variety of equality guarantees appear

90. Of course, recognition of an international human right to health care could also be instrumentally valuable to increased access to vaccines if states believe that they are bound by international human rights law. Yet many countries that recognize the existence of such do not provide adequate access to vaccines. This is weak evidence that recognition of an international right may not perfectly fulfill all the normative goals set out in Part IV. But it also stresses the importance of reminding nations about the need to provide vaccines without undermining the case that nations owe duties to provide more than just vaccines.

91. *WHO Model List of Essential Medicines, 20th List*, WHO, <http://www.who.int/medicines/publications/essentialmedicines/en/> (last visited Oct. 4, 2018).

92. UDHR, *supra* note 78, pmb., art. 1.

93. See, e.g., AHARON BARAK, HUMAN DIGNITY: THE CONSTITUTIONAL VALUE AND THE CONSTITUTIONAL RIGHT 38–43 (Daniel Kayros ed., 2015). Barak actually claims that human dignity is one of international law’s general principles of law. *Id.* at 37.

94. Comm. on Econ., Soc. & Cultural Rts., General Comment No. 15: The Right to Water, ¶ 1, U.N. Doc. E/C.12/2002/11 (Jan. 20, 2003) [hereinafter GC 15].

throughout international human rights law.⁹⁵ Non-discrimination guarantees are also common.⁹⁶ Health care guarantees may be necessary to ensure that all people receive the same level of access to health care goods that international human rights law deems necessary for specific health outcomes—such as the protection of dignity—or any other internationally recognized reason. This helps explain why equal access to quality health care goods is part of the international right to health care, why non-discrimination in health care provision is explicitly included as part of the right to health, and why international human rights law requires a functioning health care system that distributes goods in a procedurally fair, non-discriminatory manner.

The international right to health care, then, is not *solely* normatively concerned with ensuring the highest attainable standard of health where health is understood as a high level of well-being. The criteria for further specifying the health care content of the right to health likewise suggests that the strong version of the second problem above is not one that international human rights law seeks to solve. The list of goods above is not offered as an exclusive list of the health care goods to which one should be entitled under the right to health. The criteria for determining what else can be added is non-comparative with respect to social determinants. The goods must be effective.⁹⁷ They need not be more effective than (other) social determinants like a health environment, education, food, or water.

The provisions outlining the importance of dignity and other interests and undermining the comparative reading of the content of the right to health also serve as links to the other arguments below. The data that support the textual argument here could also support the ‘coherence argument’ below and the values mentioned in the passages help explain the moral reasons that it is appropriate to recognize an international right to health care. I now turn to explaining the coherence argument in detail.

95. E.g., ICESCR, *supra* note 5, art. 3; CEDAW, *supra* note 82, art. 11; UDHR, *supra* note 78, pmbl., art. 1; Fourth World Conference on Women, *Beijing Declaration*, ¶¶ 30, 44, 89, U.N. Doc. A/CONF.177/20, annex I (Oct. 17, 1995); Comm. on the Elimination of Discrimination Against Women, *supra* note 21, at 7; GC 14, *supra* note 7, ¶ 18.

96. E.g., Const. of the WHO, *supra* note 28, pmbl.; CRPD, *supra* note 5, art. 25; UDHR, *supra* note 78, art. 2. Equality and non-discrimination are also standalone rights elsewhere in the legal order. See, e.g., CRC, *supra* note 5, art. 2; GC 14, *supra* note 7, ¶ 3. ALLEN BUCHANAN, *THE HEART OF HUMAN RIGHTS* 28, 30 (2013) states that promoting equality (in the sense of equal standing) is a primary function of international human rights law in general.

97. “[H]ealth facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.” GC 14, *supra* note 7, ¶ 12 (italicization in original).

III. THE COHERENCE ARGUMENT

Even if the international right to health does not obviously include a right to health care as a matter of textual interpretation, such a right can be and should be developed from other international rights that share the right to health care's foundational concerns with dignity and equality. Interpretations of those rights support this argument. Indeed, even if the commitments to dignity and equality in the preceding section do not provide the best explanation for why international human rights law requires the provision of certain health care goods as part of the right to health, the commitments to dignity and equality explain why international human rights law should recognize a right to health care either as part of a broader right to health or as a standalone right. Again, in short, the provision of certain health care goods is required to ensure people can access the goods necessary to enjoy a dignified life and, where all nations provide some health care, recognizing a right to health care is a valuable means to ensuring equality and non-discrimination in that health care distribution process. From this perspective, the aforementioned indivisibility of human rights actually counts in favor of recognition of an international human rights law.⁹⁸ Dignity, equality, and non-discrimination rights are best understood as partially constituted by a right to health care and make the most sense when they are part of a normative order that recognizes a right to health care. Thus, even if dignity, equality, and non-discrimination do not provide a sufficient limiting principle for identifying the scope of the international right to health care,⁹⁹ international human rights law's commitments to dignity, equality, and non-discrimination suggest that the right to health does not need to be read in a manner that is solely concerned with health outcomes but instead reflects commitments to many values that support an international right to health care.

International law that is not concerned with human rights likewise suggests that international law in general recognizes the primary importance of (and, arguably, right to) health care. International trade law, particularly the component of international trade law devoted to patents ('international patent law'), provides the best example. Exceptions to international patent law suggest that it too recognizes the importance of health care and carves out rights to benefit from health care achievements that can plausibly be understood as aspects of a right to health care. At the very least, these exceptions establish international human rights law's normative commitment to the importance of health care, which supports the coherence argument for an international human right to health care. Where

98. See *supra* note 29.

99. For the problem of identifying a proper limiting principle, see Michael Da Silva, *A Goal-Oriented Understanding of the Right to Health Care and Its Implications for Future Health Rights Litigation*, 39 DALHOUSIE L.J. 377 (2016); Da Silva, *Realizing the Right to Health Care in Canada*, *supra* note 1.

international trade law recognizes access to health care as creating a constraint on the freedom to maximize general market principles, international trade law could also be understood as recognizing health care as a right that can conflict with general trade rights but must be balanced with trade rights and general market demands to maximize each.

The case for the international right to health care from international trade law is likely more surprising and thus requires more elaboration than the cases from dignity and equality. To begin, the General Agreement on Tariffs and Trade (the “GATT”) recognizes a general exception to its standard rules, which are designed for trade liberalization, for measures “necessary to protect human, animal or plant life or health.”¹⁰⁰ This provision on its own is consistent with a view that international law prioritizes health rather than health care. Indeed, the leading judicial interpretation of the provision is primarily concerned with health outcomes, and the main issue on appeal was the evidence that the subject matter of the case—*asbestos*—impacts health in a way that justifies an import ban (and, as an extension, whether less restrictive means could produce the same health outcomes).¹⁰¹ But the provision does establish that even international trade law acknowledges that certain health commitments should be capable of constraining international trade law’s own dominant trade liberalization norms. Further exceptions then appear to create space for state measures designed to ensure adequate health care. For instance, the same article of the GATT creates general exceptions for measures “involving restrictions on exports of domestic materials necessary to ensure essential quantities of such materials to a domestic processing industry during periods when the domestic price of such materials is held below the world price as part of a governmental stabilization plan” and “essential to the acquisition or distribution of products in general or local short supply.”¹⁰² Such provisions could theoretically apply to health care goods, particularly when a state fails to fulfill the right to health care obligations I defend throughout this piece due to an inability to manufacture the goods in the first case or resource constraints in the second.

100. Agreement on the Application of Sanitary and Phytosanitary Measures art. 2, Apr. 15, 1994, Marrakesh Agreement Establishing the World Trade Organization, annex 1A, art. XX(b) 1867 U.N.T.S. 493.

101. Appellate Body Report, *European Communities—Measures Affecting Asbestos and Asbestos-Containing Products*, WTO Doc. WT/DS135/AB/R (adopted Apr. 5, 2001). The criteria for technical regulations are the other primary issue in that dispute. As noted in that case, for example, *id.* ¶¶ 113–116, 128, and in a concurring statement at para 152), the health impact of goods is partially constitutive of them for the purposes of a like product comparison. While the case goes on to suggest that states can “determine the level of protection of health that they consider appropriate” for the purposes of the GATT, *id.* ¶ 168, it is notable that the health exception remains, and this variance was used to allow greater health protections that some would have allowed under the GATT.

102. General Agreement on Tariffs and Trade art. XX(i)–(j), Oct. 30, 1947, 61 Stat. A-11, 55 U.N.T.S. 194 [hereinafter GATT].

The part of international trade law focused on patents makes the importance of health *care* even clearer. Pharmaceuticals were placed under the international patent law regime in the Agreement on Trade-Related Aspects of International Property Rights (the “TRIPS”).¹⁰³ That agreement was designed to balance two competing goals of international law. Both goals are, notably, fundamentally focused on the importance of health care, suggesting an even greater priority for health care than the balancing discussed in the previous paragraph would support:

The TRIPS Agreement represents an attempt at the multilateral level to achieve the difficult task of balancing the interest of providing incentives for research and development of new drugs with the interest of making these drugs as widely accessible as possible to patients needing them.¹⁰⁴

Only the latter goal focuses exclusively on individual access to goods and is plausibly understood as a reflection of the need for a right to health care. Yet the fact that the agreement is committed to balancing and includes exceptions to the TRIPS’s codified international intellectual property norms emphasizes the fact that international trade law recognizes the importance of individual access to health care and is normatively consistent with the existence of an international right to health care. Indeed, the guiding principles of the TRIPS are consistent with recognition of the importance of public health, which may be part of or contribute to health care.¹⁰⁵ Article 8 of the TRIPS thus states that:

1. Members may, in formulating or amending their laws and regulations, adopt measures necessary to protect public health and nutrition, and to promote the public interest in sectors of vital importance to their socio-economic and technological development, provided that such measures are consistent with the provisions of this Agreement.
2. Appropriate measures, provided that they are consistent with the provisions of this Agreement, may be needed to prevent the abuse of intellectual property rights by right holders or the resort to

103. Agreement on Trade-Related Aspects of Intellectual Property Rights, Apr. 15, 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1C, 1869 U.N.T.S. 299 [hereinafter TRIPS].

104. ANTONY TAUBMAN ET AL., A HANDBOOK ON THE WTO TRIPS AGREEMENT 179 (2012); *Fact Sheet: TRIPS and Pharmaceutical Patents: Obligations and Exceptions*, WORLD TRADE ORG. (Sept. 2006), https://www.wto.org/english/tratop_e/trips_e/factsheet_pharm02_e.htm (last visited Oct. 4, 2018) [hereinafter *Fact Sheet*].

105. Recall the definition of health care in Callahan, *supra* note 37.

practices which unreasonably restrain trade or adversely affect the international transfer of technology.¹⁰⁶

Later interpretations of public health under the TRIPS specifically identify access to patented medicines as public health concerns and state that the TRIPS should be read in conformity with a commitment to public health.¹⁰⁷ Yet these principles still require compliance with the TRIPS.

Further health-related exceptions emphasize the importance of health care in international law by providing a means to avoid the application of international trade law in order to increase access to health care. The TRIPS does not provide a blanket exception for any class of inventions, so pharmaceuticals and medical technologies as classes are subject to patent law norms that could undermine access to health care absent some other explicit exception.¹⁰⁸ But the TRIPS includes permissive exceptions that allow nations to not protect all *prima facie* patentable goods, and these exceptions were designed with pharmaceuticals in mind (given the fact that pharmaceuticals were the chief source of controversy at the time the TRIPS was negotiated) and are most often used in the pharmaceutical context. Most famously, Article 30 of the TRIPS states that “Members may provide limited exceptions to the exclusive rights conferred by a patent, provided that such exceptions do not unreasonably conflict with a normal exploitation

106. TRIPS, *supra* note 103, art. 8.

107. World Trade Organization, Ministerial Declaration of 14 Nov. 2001, WTO Doc. WT/MIN(01)/DEC/2, 41 ILM 755 (2002) [hereinafter Doha]; TAUBMAN ET AL., *supra* note 104, at 179–80. Article 4 of Doha states:

“We agree that the TRIPS Agreement does not and should not prevent members from taking measures to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted and implemented in a manner supportive of WTO members’ right to protect public health and, in particular, to promote access to medicines for all.”

The fact that developing countries sought “a declaration recognizing their right to implement certain pro-competitive measures, notably compulsory licenses and parallel imports, as needed to enhance access to health care” and only secured Article 4 could undermine the import of health care under international trade law. CARLOS CORREA, *IMPLICATIONS OF THE DOHA DECLARATION ON THE TRIPS AGREEMENTS AND PUBLIC HEALTH 9* (2002), http://www.who.int/medicines/areas/policy/WHO_EDM_PAR_2002.3.pdf (last visited Oct. 4, 2018). But recognizing limitations on the import of health care and the need to balance interests only undermines the case for a right to health care on a view of rights as “trumps” (to use language made famous in RONALD DWORKIN, *TAKING RIGHTS SERIOUSLY* (1977)) seriously that is inconsistent with international human rights law and most contemporary scholarship on the nature of rights. Notably, however, the precise legal status of the Doha Declaration is contested. Duncan Matthews, *WTO Decision on Implementation of Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health: A Solution to the Access to Essential Medicines Problem?*, 7 J. INT’L ECON. L. 73, 82–83 (2004).

108. TRIPS, *supra* note 103; TAUBMAN ET AL., *supra* note 104, at 98 (making this point in the case of medical technologies).

of the patent and do not unreasonably prejudice the legitimate interests of the patent owner, taking account of the legitimate interests of third parties,” while Article 31 grants Members permission to pass laws allowing “for other use of the subject matter of a patent without the authorization of the right holder, including use by the government or third parties authorized by the government” subject to specified conditions.¹⁰⁹

Controversy on how to interpret Article 30 continues.¹¹⁰ But it is clear that the exceptions cannot unreasonably conflict with normal exploitation of the patent or unreasonably conflict with the patent owner’s interest in such regular use.¹¹¹ It is also clear that one can offer regulatory exceptions for the purposes of research and for obtaining marketing approval for a generic version of a patented good.¹¹² This can speed up access to generic pharmaceuticals. The case on the use of Article 30 that established the test for compliance was explicitly designed to do so.¹¹³ Per that case, even when Article 30 exceptions are passed with only pharmaceuticals in mind and only pharmaceutical regulators can make use of them, they can pass World Trade Organization (“WTO”) scrutiny despite the ban on blanket exceptions for classes of goods so long as they do not solely apply to pharmaceuticals.¹¹⁴

Article 31, in turn, permits multiple exceptions to patent protections. Most notably, it permits nations to grant ‘compulsory licenses’ that allow third parties to produce patent products without the permission of the patent holder.¹¹⁵ Under the compulsory license regime,

the public interest goal of achieving broader access to the patented invention is considered more important than the private interest of the right holder in fully exploiting his exclusive rights. What this means in the context of public health imperatives is that

109. *Id.* arts. 30–31.

110. Matthews, *supra* note 107, at 88–92.

111. Panel Report, *Canada – Patent Protection of Pharmaceutical Products*, WTO Doc. WT/DS114/R (adopted Apr. 7, 2000) [hereinafter *Canada*]; TAUBMAN ET AL., *supra* note 104, at 108; *Fact Sheet*, *supra* note 104. Part of the controversy discussed in Matthews, *supra* note 107, at 88–92 concerns the scope of the finding in that case. Some early interpreters read the exception as not allowing any commercial use of the final product and limiting the use to sole approval alone, but research purposes appear to also be allowed on the text of the case and subsequent interpretations listed in this footnote and subsequent practice discussed therein treat the case as having this effect.

112. *Canada*, *supra* note 111; see also Margaret K. Kyle & Anita M. McGahan, *Investments in Pharmaceuticals Before and After TRIPS*, 94 REV. ECON. & STAT. 1157, 1159 (2012).

113. See generally *Canada*, *supra* note 111.

114. *Id.* ¶¶ 171–74.

115. Although the language of TRIPS does not explicitly refer to compulsory licenses, article 31 of TRIPS has been recognized as referring to these licenses; *Fact Sheet*, *supra* note 104.

compulsory licensing is intended to permit countries to produce generic drugs that are more affordable than patented proprietary medicines.¹¹⁶

Such rules are intended to have public health effects. The Doha Declaration on the TRIPS Agreement and Public Health makes this clear.¹¹⁷ The declaration itself was partly a response to the issue of access to essential medicines that was brought into the center of public debate by a proposed suit from the Pharmaceutical Manufacturers Association of South Africa challenging compulsory licensing in that nation and by a contemporaneous dispute between Brazil and the United States of America at the WTO.¹¹⁸ Post-Doha, regional trade agreements can produce Article 31 exceptions under some circumstances,¹¹⁹ creating further possibilities for exceptions focused on ensuring access to health care.

Finally, under Article 27 of the TRIPS:

2. Members may exclude from patentability inventions, the prevention within their territory of the commercial exploitation of which is necessary to protect *ordre public* or morality, including to protect human, animal or plant life or health or to avoid serious prejudice to the environment, provided that such exclusion is not made merely because the exploitation is prohibited by their law.

3. Members may also exclude from patentability:

(a) diagnostic, therapeutic and surgical methods for the treatment of humans or animals; [and other items beyond the scope of this work.]¹²⁰

The provisions concerning the protection of health could allow for even broader protections where health care is necessary for public order of morality. In practice,

[i]n their legislation, Members have generally understood that this permissible exclusion from patentability applies to methods for the treatment of humans or animals, not to medical or veterinary products, including devices, substances and compositions, for use in any of these methods. Under this approach, while a new and inventive way of removing a cataract from the eye may be excluded

116. Matthews, *supra* note 107, at 77.

117. Doha, *supra* note 107.

118. Matthews, *supra* note 107, at 78–81.

119. TAUBMAN ET AL., *supra* note 104, at 190.

120. TRIPS, *supra* note 103, art 27.

from patent protection, an instrument invented to perform this new surgical method would not be so excluded.¹²¹

Yet domestic legislation does not actually say how nations view the permissibility. Rather, it shows what they are willing to do in their own states. So, while this state practice is weak evidence of custom, it does not definitively determine the scope of Article 27 exceptions.¹²²

These exceptions may not (and likely will not) perfectly promote access to health care. They are, rather, reflections of international trade law's commitment to the importance of health care. The value and potential of these exceptions as tools for actually increasing access to health care, especially medicines and particularly in low-income countries, are constantly questioned and remain contested.¹²³ Shortly after the TRIPS, the state of the field could be described as follows:

Experts agree that there is space within the text of the agreement which, if exploited fully but responsibly, can help countries to safeguard their public good objectives with reference to availability of essential drugs, e.g. provisions of compulsory licensing, parallel imports, etc.¹²⁴

Yet, even then, some questioned whether they would be so exploited. The empirical record since that time is mixed.¹²⁵ But, as the forgoing made clear,

121. TAUBMAN ET AL., *supra* note 104, at 103.

122. See also sources cited *supra* notes 7, 23.

123. See, for example, the following, which exemplify periodic recitals and discussions of pros and cons and propose their own reforms: Coenraad Visser, 'Affordable Medicines' Exceptions to Patent Rights Under the TRIPS Agreement: Some Pointers for South Africa?, 34 COMP. & INT'L L.J. S. AFR. 377 (2001); SISULE F. MUSUNGU ET AL., UTILIZING TRIPS FLEXIBILITIES FOR PUBLIC HEALTH PROTECTION THROUGH SOUTH-SOUTH REGIONAL FRAMEWORKS (2004); Matthews, *supra* note 107; Richard D. Smith et al., *Trade, TRIPS, and Pharmaceuticals*, 373 LANCET 684 (2009); Ebenezer K. Tetteh, *Pharmaceutical Innovation, Fair Following and the Constrained Value of TRIPS Flexibilities*, 14 J. WORLD INTELL. PROP. 202 (2011); Anh L. T. Tran, *Patent Law and Public Health Under the TRIPS Agreement Standards: How Does Vietnam Benefit from the WTO Membership?*, 14 J. WORLD INTELL. PROP. 334 (2011); Pradip Royhan, *Market Access Challenges and Opportunities for Bangladesh Pharmaceutical Products Under TRIPS*, 8 J. INTELL. PROP. L. & PRAC. 932 (2013); Marumo Nkomo, *The Trade Related Aspects of Intellectual Property Rights (TRIPS) - Pharmaceuticals Transitional Period: Can It Help Build Capacity in African Least Developed Countries (LDCs)?*, 10 INT'L J. AFR. RENAISSANCE STUD. 48 (2015).

124. Zafar Mirza, *WTO/TRIPS, Pharmaceuticals and Health: Impacts and Strategies*, 42 DEV. 92, 96 (1999).

125. Flexibilities are rarely used. CORREA, *supra* note 107; MUSUNGU ET AL., *supra* note 123. Doha, *supra* note 107, ¶ 6 arguably highlighted that this was the case for nations that lacked manufacturing capacities in 2001: "We recognize that WTO members with insufficient or no manufacturing capacities in the pharmaceutical sector could face difficulties in making effective use of compulsory licensing under the TRIPS Agreement. We instruct the Council for TRIPS to find an expeditious solution to this problem and to report to the General Council before the end of 2002." It is not clear that this problem is solved in 2018, let alone

the exceptions are meant to ensure increased access to health care. International legal actors recognize that these norms are relevant to international human rights law. The connections between different areas of international law are particularly salient in the context of health care and trade. The WHO, the World Intellectual Property Organization (the “WIPO”), and the WTO work together to balance patent norms.¹²⁶ The Human Rights Council, High Commissioner for Human Rights, and Human Rights Council-appointed special rapporteurs on a variety of rights all look at the TRIPS from a human rights perspective, often focusing on the right to health.¹²⁷

One may argue that even subjecting pharmaceuticals to international trade law suggests that international law is hostile to the importance of pharmaceuticals. Regulating pharmaceuticals was one of the most controversial topics at the meetings that led to the TRIPS.¹²⁸ Pharmaceutical companies led the charge for placing pharmaceuticals under patent regulations.¹²⁹ Many critics suggest that recognizing that it is appropriate to place health care goods under international trade law’s patent provisions may undermine access to essential medicines.¹³⁰ However, there is reason to think that patent protections could provide greater access to health care and improved health outcomes in the long-term.¹³¹ And even if this were not the case,¹³² recognizing that pharmaceuticals are and should be part of international trade law is consistent with acknowledging special priority for pharmaceuticals within that trade law regime. Indeed, international law highlights the importance of ensuring access to medicines, creating exceptions to the general rules on patents that tend to be applied to health law. Recognizing that health care is part of trade law may create some barriers to health care that would not exist in a fully unregulated international marketplace, but international trade law—and the international patent law that exists therein—exists, and its normativity is consistent with other provisions in its priority for protecting access to health care. In other

that it was solved in 2002. This deadline was missed, much like the one identified in the *Declaration of Alma-Ata*, *supra* note 26 that I highlighted above.

126. TAUBMAN ET AL., *supra* note 104, at 195.

127. *Id.* at 216–17.

128. Mirza, *supra* note 124, at 93.

129. *Id.*

130. Royhan, *supra* note 123, at 932 (“A consensus has emerged among developing countries that the patent rights for pharmaceutical products guaranteed by TRIPS are a substantial barrier to the policy formulation for ensuring affordable access to medicines for their people”). *But see* Nkomo, *supra* note 123, at 63 (noting that these arguments were adduced well before developing nations were required to recognize pharmaceutical patents and were thus raised well before any empirical evidence could even support them).

131. Mirza, *supra* note 124, at 93–94, raises this possibility, though he was unable to empirically measure it in 1999.

132. See, for example, Kyle & McGahan, *supra* note 112, at 1157, for evidence that it does not increase innovation sensitive to the needs of developing countries.

words, if international trade law is going to exist in this domain, global leaders recognize that its negative impacts on access to health care must be minimized. Exceptions to the general rules on patents follow suit.¹³³

One could argue that these exceptions are political concessions rather than indications of the primary importance of health care in international trade law, let alone international law *simpliciter*. But the argument from coherence takes the law as given and seeks to explain it in a normatively acceptable way. An argument from historical origins would have a different form. It is, of course, true that all international laws have political origins. The recognition of social, cultural, and political rights was itself contentious. Different covenants for different kinds of rights were themselves a compromise.¹³⁴ To the extent that any international covenants are normative—despite being the products of international politics—the same is true of the exceptions to international trade law. The current task is to render the product of these political practices normatively explicable.¹³⁵

The international trade component of the coherence argument is, admittedly, more ambitious than the components focused on international human rights law and human rights norms. The international trade law component particularly faces a structural counterargument that other components do not face, but that counterargument can be overcome. In short, the counterargument suggests that one cannot build a positive right out of negative derogations clauses like those in the TRIPS (or the GATT). While international human rights law produces explicit equality and non-discrimination rights and freedoms that can plausibly be used to develop a positive right to health care, the international trade law passages I identify do not create any rights or even positive obligations. You cannot, a critic may charge, create a positive out of a negative. The easiest way to avoid this criticism is to deny the positive/negative rights and duties distinction. Many

133. I grant that additional conditions on trade outside the WTO framework have led many nations to require “TRIPS-plus requirements” for continued trade, which undermine efforts to prioritize drugs. Smith et al., *supra* note 123, at 687–88; Kevin Outterson, *Fair Followers: Expanding Access to Generic Pharmaceuticals for Low- and Middle-Income Populations*, in *THE POWER OF PILLS* 164 (Jillian C. Cohen et al. eds., 2006). This does not change the fact that international law’s main components recognize the importance of health care and see access to health care as an important interest against which they must weigh the goal of innovation, which is itself important partly due to its ability to provide new and better health care.

134. For good discussions of these historical controversies that emphasize the controversies’ impact on the right to health, see *THE RIGHT TO HEALTH AS A HUMAN RIGHT IN INTERNATIONAL LAW* (Brigit Toebes et al. eds., 1999); JOHN TOBIN, *THE RIGHT TO HEALTH IN INTERNATIONAL LAW* (2012).

135. For a similar method, see MACKLEM, *supra* note 7.

scholars do so when arguing for positive rights.¹³⁶ But, as I note elsewhere, that distinction is valuable elsewhere (particularly in ethics).¹³⁷

Fortunately, a less problematic response is possible and plausible. I am unclear on why one would think that a positive cannot be built out of a negative more generally. But this paper relies only on a commitment to the view that one can recognize both positive rights and negative liberties as reflective of values. Where the rights and liberties are supposed to exist as part of a unified whole, expressions of value underlying a liberty can be used to support a right and vice versa. Moreover, we should want the normative order underlying the whole to be coherent and should read provisions of law in a manner consistent with underlying values of other areas of law. The coherence argument suggests that international human rights law and international trade law alike acknowledge the primary import of health care for reasons that are not strictly concerned with increased health outcomes at the population level. This supports reading the right to health in a manner with similarly multifaceted aims. Such a reading supports a right to health care. While the commitment to the primary import of health care in international trade law is a less explicitly normative commitment than international human rights law's commitment to the value of dignity, I provided textual support that supports at least an implicit commitment to this view. Not all underlying values of international law will be identifiable, and they will conflict, but one should attempt to identify as many as possible and to make them as coherent as possible. Recognition of an international right to health care is consistent with such an approach.

International trade law too, then, recognizes the importance of health care. Recognizing its import in our interpretation of the right to health and creating a right to health care as part of that broader right coheres with this international trade law norm. As noted above, such recognition also coheres with other parts of international human rights law, such as its recognition of dignity, equality, and non-discrimination rights and its statements that all these rights and the right to health are indivisible. This is the coherence argument for the international right to health care.

IV. THE MORAL VALUE OF RECOGNITION

As demonstrated above, recognition of an international right to health care is supported by both the text of international human rights law documents and the underlying normative structure that appears to undergird international law. Recognition of such a right is thus valuable for making sense of the content of international law and establishing its coherence. Where we desire a normatively coherent international legal order, either as a

136. STEPHEN HOLMES & CASS R. SUNSTEIN, *THE COSTS OF RIGHTS* (1999).

137. Michael Da Silva, *Review Essay: Jeff King, Judging Social Rights*, 9 *VIENNA J. INT'L CONST. L.* 463, 470 n.47 (2015).

means of establishing its general authority or for its own sake, this alone provides reason to think that recognition of an international right to health care is not only necessary as a means of positive international human rights law, but normatively desirable.

Still, other moral reasons also count in favor of recognizing the right. The argument in this paper primarily concerns the positive law. A full moral case for rights to health care outside the realm of international law is beyond the scope of this piece. Yet there are other moral reasons to recognize such a right as a matter of international law. It is worth briefly mentioning them here. Their importance is then further developed in Parts V and VI, in which I explain how this approach avoids the problems in Part I and some of the most damning lingering objections to my argument.

First, recognition is morally valuable for expressive purposes. If the forgoing is correct, then recognition of an international right to health care is also valuable as a means of explicitly highlighting our commitments to other important moral values, such as dignity, equality, and non-discrimination. International recognition of the importance of the means of realizing these values, in addition to international recognition of the values as subjects of standalone rights, is a further sign of commitment to their importance. There is thus good reason to recognize an international right to health care.

Second, recognizing the international right to health care is desirable insofar as it presents clear, achievable action items for realizing human rights. As noted above, it is difficult to outline the scope of the right to health's social determinant components, the exact nature of its attendant duties, and the extent to which given interventions contribute to realization thereof. Given the wide range of social determinants of health, it seems like we need to change the very structure of the world to fully realize the right to health. While some people believe it is easier to change society than to change individuals, the same people recognize that this appears utopian.¹³⁸ Even if it is not impossible, it makes it difficult to determine where to start. We should not let the perfect be the enemy of the good and mistake the potential impossibility of fully realizing the right to health with the non-existence of duties to fulfill it. But we also need to know where to begin and how to know if we are contributing to improved realization thereof. The strong comparison requirement in the second problem above combined with the causation concerns in the previous paragraph would make this very difficult. The international right to health care, by contrast, specifies measurable goods that must be provided to fulfill the right. The number of goods that are absolutely required for dignity concerns is sufficiently small as to be potentially realizable. Health care thus provides an easy starting point in a longer path toward improved human rights realization. While we must be careful not to misplace priorities, the limited scope of the

138. See, e.g., Marmot, *supra* note 40, at S21.

international right to health care's core avoids the worst parts of this concern (as I detail below).

Third, recognition is morally valuable insofar as it requires governments to provide the goods necessary for a minimally dignified existence. Recognition can be an actual tool for ensuring more people live dignified lives, which would be a moral good. International human rights law's weak normative status in some jurisdictions and its lack of an enforcement mechanism limits this potential value of recognition. But providing additional legal tools for bringing people up to the level of well-being necessary for dignity can be helpful and could be a means of helping realize other important moral ends, including the realization of other, less controversial human rights. Likewise, fourth, an international human right to health care can be a tool for health care justice insofar as international legal arguments are seen in some way as persuasive in the jurisdiction in question.

Fifth, recognition of an international right to health care makes international human rights law consistent with global transnational norms. A majority of world constitutions now recognize a right to health care.¹³⁹ Many people in nations without constitutional health rights believe they have a right to health care.¹⁴⁰ International recognition of such a right can provide guidance on how to understand these domestic rights as part of a larger transnational legal process and makes sense of right to health care claims outside the nations that explicitly recognize such a right in their constitutions. As I argue elsewhere, the form of this apparent international right to health care is actually consistent with the normatively acceptable claims made by health rights litigants throughout the globe, suggesting that international recognition is already part and parcel of a global health rights phenomenon.¹⁴¹

Finally, recognition avoids some of the conceptual problems facing the right to health care. For instance, it explains how one can have a right that does not fit the traditional claim-right model. If the long history of the right to health is, in part, a history of a workable right to health care that does not

139. Eleanor D. Kinney, *The International Right to Health: What Does It Mean for Our Nation and World?*, 34 *IND. L. REV.* 1457, 1464–65 (2001); Eleanor D. Kinney & Brian Alexander Clark, *Provisions for Health and Health Care in the Constitutions of the Countries of the World*, 37 *CORNELL INT'L L.J.* 285, 291 (2004); Courtney Jung et al., *Economic and Social Rights in National Constitutions*, 62 *Am. J. Comp. L.* 1034, 1054 (2014).

140. For example, many Canadians believe they have a right to health care. ROY J. ROMANOW, *COMM'N ON THE FUTURE OF HEALTH CARE IN CAN., BUILDING ON VALUES: THE FUTURE OF HEALTH CARE IN CANADA* 243 (2002). The Canadian statute guaranteeing public health is accordingly critical to the self-identity of many Canadian citizens. Colleen M. Flood & Michelle Zimmerman, *Judicious Choices: Health Care Resource Decisions and the Supreme Court*, in *HEALTH LAW AT THE SUPREME COURT OF CANADA* 25 (Jocelyn Downie & Elaine Gibson eds., 2007).

141. Da Silva, *Realizing the Right to Health Care in Canada*, *supra* note 1; Da Silva, *A Goal-Oriented Understanding*, *supra* note 99.

fit the claim-right model, this is some evidence that there can be rights that do not fit that model.¹⁴²

With these reasons in mind, I now turn to discuss how recognition of the right in the manner described above addresses the specific conceptual problems facing the international right to health care detailed above.

V. SOLVING THE PROBLEMS WITH A RIGHT TO HEALTH CARE

The forgoing account helps avoid each of the three problems facing the international right to health care that I identified in Part I. The first concern is most easily avoided. In short, the forgoing grants that the majority of provisions outlining the international right to health focus on social determinants of health, but simply responds by noting that there is a consequential minority of provisions that highlight entitlements to specific health care goods and to the fair distribution of health care goods. One cannot ignore these provisions in a good faith interpretation of the law and should try to make sense of their inclusion in international law. Acknowledging them as health care components of the right to health makes the most sense. Recognizing an international right to health care is necessary to acknowledge the many health care-related provisions of international human rights law.

The forgoing also addresses the second problem facing a right to health care. If the international right to health care is not understood as solely concerned with increasing health at the population level, then its comparatively weak ability to improve such health outcomes will not unduly limit its scope. If the right is understood as focused on both improving health at the population level and ensuring that individuals can live a minimally dignified existence, then the right need not be overly expansive, running into the motivating animus between the second problem above. Recognizing a right to health care need not be monolithic on this construction. It accordingly need not lead to misplaced priorities that ignore the importance of social determinants of health as contributors to the important right to health.

One issue with this response to the second problem lingers, but it can be addressed. The forgoing does suggest that a health care entitlement does not

142. Granted, other international rights that do not fit this model provide the same evidence, but it is helpful for health rights advocates to have proof that non-traditional health rights can work. The preceding is not an exhaustive list of moral arguments for why recognition of an international right to health care is justified. It is certainly not an exhaustive list of reasons for why we recognize health care rights generally, why health care has any special moral status, or even why we should care about it given the relative value of health care and the social determinants of health. But it is a strong set of arguments for my narrower claim. The literature on the broader topic is vast. For an interesting recent piece that takes a different tack on the last point, see Gabriele Badano, *Still Special, Despite Everything: A Liberal Defence of the Value of Healthcare in the Face of the Social Determinants of Health*, 42 SOC. THEORY & PRAC. 183 (2016).

need to be comparatively better than social determinants of health in contributing to health. Insofar as health is necessary for dignity, we might think that this account cannot avoid the second concern, even if it is primarily concerned with dignity. After all, if the social determinants are better contributors to health, they would be better contributors to dignity by extension. One could counter this by noting that the right to health's emphasis on social determinants of health highlights its focus on population health while dignity addresses the health of individuals. Such a statement is likely true. Yet, ultimately, a healthy environment is even more likely to produce healthy individuals. So, one must deny the strict comparison requirement for rights realization upon which the strongest version of the second problem rests. Luckily, however, international human rights law does not generally include this requirement. Indeed, the provisions above guaranteeing specific health care entitlements would be nonsensical if such a requirement existed. My account's denial of the comparison requirement is thus supported by international human rights law, and I can deny the existence of the purported requirement in order to properly address the second problem above.

The approach above also avoids the third concern. While the international right to health care does require a minimally functioning health care system, international human rights law is generally agnostic as to the form that this system would take, allowing the right to coexist with the fundamental norms of state sovereignty undergirding international law more broadly. This agnosticism also highlights the way in which the health care system requirement is only a part of the broader right. The right is otherwise structurally identical to other economic, cultural, and social rights. Where the international right to health care is understood as a complex right with multiple components, it can survive the challenge that one component fails to accord with the structure of other rights. If all rights are similarly complex and/or all rights otherwise share the same structure, then the international right to health care could survive without its systemic component even if the third challenge hit its mark.

Yet there are also signs that other rights share the purportedly anomalous systemic duty element of the international human right to health care and good reason to think that this feature should be a component of international rights. The right to water is a good example of a right that shares the right to health care's structure. The right to water is not only rooted in dignity, but is also connected with other rights, such as the rights to health and food.¹⁴³ Its scope is not only limited to "the provision of adequate nutritious foods and clean drinking water,"¹⁴⁴ something that arguably requires a water management system for realization. It also explicitly includes "ensuring that disadvantaged and marginalized farmers,

143. GC 15, *supra* note 94, ¶¶ 1, 3, 6.

144. *Id.* ¶ 4 (quoting CRC, *supra* note 5, art. 24, ¶ 2).

including women farmers, have equitable access to water and water management systems, including sustainable rain harvesting and irrigation technology” and “the right to a system of water supply and management that provides equality of opportunity for people to enjoy the right to water.”¹⁴⁵ The right clearly requires establishing a functioning water supply and management system, which is analogous to the right to a functioning health care system as part of the international right to health’s health care component. It also recognizes the need for national strategies and policies. The authoritative interpretation guarantees:

sufficient recognition of this right within the national political and legal systems, preferably by way of legislative implementation; adopting a national water strategy and plan of action to realize this right; ensuring that water is affordable for everyone; and facilitating improved and sustainable access to water, particularly in rural and deprived urban areas.¹⁴⁶

This is remarkably similar to the passage preferring legislative entrenchment of national health care systems and national health care policies and strategies in GC 14.¹⁴⁷ As with the seeming international right to health care, moreover, the right to water is not *solely* systematic in nature. It also includes a minimum floor of individualized content. For instance, the CESCR’s authoritative interpretation of the right to water states that “[t]he elements of the right to water must be *adequate* for human dignity, life and health.”¹⁴⁸ This dignity-based adequacy threshold keeps the right from being monolithic. Procedural safeguards above this minimum are also present.¹⁴⁹

From this perspective, the right to health care appears to fit a shared structure of new international human rights that is complex in nature, recognizing a minimal floor of content, procedural fairness above it, and the need to create a full system as a means of ensuring realization of the other components. It is not only the case that the right to health care is not unique in its structure. It is further the case that the right is in the vanguard of a new form of rights recognition and that this vanguard does not fundamentally undermine the established structure of rights insofar as it is consistent with well-recognized CESCR practice. From this perspective, for instance, the right to food is an outlier in not requiring a system of distributing food, and this unique feature can be partially explained by the fact that people can feed themselves from the land; any right to a system as part of the right to

145. *Id.* ¶¶ 7, 10.

146. *Id.* ¶ 26; *see also id.* ¶ 47 (requiring a “national strategy or plan of action”). As with the right to health care, such a strategy must have indicators and benchmarks. *See id.* ¶¶ 53–54.

147. GC 14, *supra* note 7, ¶ 36.

148. GC 15, *supra* note 94, ¶ 11.

149. *E.g., id.* ¶¶ 10, 12–16.

food is thus a backstop against a failure to protect the natural resources needed to feed one's self.¹⁵⁰ That right actually does include a requirement to create a food strategy that speaks to how any system in place will operate,¹⁵¹ so there is more consistency between the structure of that right and the structure of the right to health than one might think on first reading of the relevant law.

But one does not need to subscribe to this more radical view to avoid the third problem above. All that is needed to address the third problem is to show that some other rights fit this form, and so a right to health care built on the health care-related statements articulating the right to health would not be a complete outlier in international human rights law. Comparison with the right to water, for one, establishes this more modest claim.¹⁵²

It is also worth noting that the right to health arguably runs into the third problem even if one takes a social determinants-focused approach to the right to health. The Rio Political Declaration on the Social Determinants of Health included "effective systems of preventing and treating ill health" among the social factors that cause health inequities and explicitly highlighted "a universal, comprehensive, equitable, effective, responsive and accessible health care system" as a requirement for good health.¹⁵³ This passage is not only further evidence in support of the textual argument above. It also establishes the need for a health care system as part of the right to health. So even if we do not recognize an international right to health care as part of the right to health, we need to recognize a right to a functioning health care system as part of the international right to health. If the third problem above undermines the right to health care, it should also undermine the right to health. But we cannot avoid recognizing the right to health as a matter of international law. From a positive law perspective, then, we should not recognize the third problem as undermining the case for a right to health care. Health rights appear to have required systemic components.¹⁵⁴

150. Food GC, *supra* note 71, ¶ 12.

151. *Id.* ¶ 25.

152. Of course, the right to water is not in the ICESCR or other canonical human rights documents. *See, e.g.*, UDHR, *supra* note 78, ICESCR, *supra* note 5, and International Covenant on Civil and Political Rights, *opened for signature* Dec. 16, 1966, 999 U.N.T.S. 171. Drawing on an analogy with a contested right to establish a contested right is less than ideal. But the CESCR clearly now recognizes the right to water and a right to health care, and the CESCR's interpretations are authoritative human rights law documents. Moreover, I present ample other reason to recognize a right to health care above. If one does not accept CESCR statements as authoritative in the first place, then the third problem with a right to health care likely does not arise. The best textual evidence for a systemic component of the international right to health care is in GC 14. As noted above, the respect, protect, and fulfill doctrine also provides some support, if not full support, for the systemic requirement.

153. *Rio Declaration*, *supra* note 22, at 48, ¶¶ 6–7.

154. Notably, the provision of sanitation services as part of the right to water is also considered part of the right to health. *See* GC 15, *supra* note 94, ¶ 29. Insofar as this too

VI. OBJECTIONS AND REPLIES

Positive international human rights law is enormous and controversial. It is likely that every argument in this domain is open to numerous objections. My argument for the international right to health care above is no different. In this final section, I address some of the most damning potential criticisms.

A. *One Cannot Properly Identify the Content of an International Right to Health Care*

The first objection one might raise is that articulating the scope of a right to health care is problematic in its own right and likely impossible. Elsewhere, I identified four challenges facing any attempt to fill the content of a right to health care (in ethics or law): (1) “the argument from the nature of rights” (“there can be no right to health care because no one owes a duty to fulfill that right”), (2) “the problem of scope” (it is difficult to set a non-arbitrary stopping point between an overly expansive right to all health care goods and a specific right to one health care good), (3) “the problem of principles of scope” (“it is difficult to articulate a *principle* for selecting which goods ought to be covered”), and (4) “the problem of time and space” (“the list of goods required to fulfill a right to health will vary over time and space as new goods are developed,” so it is difficult to specify the content at any given time in any given place).¹⁵⁵ These are genuine problems for a moral conception of the right to health care. But they are not damning problems for the international right to health care or the textual and moral arguments for such a right presented above.

Regardless of whether one thinks that a right to health care can avoid these problems generally—and I argue that it can elsewhere¹⁵⁶—the international right to health care deals with them admirably. It states that governments owe the chief corresponding primary duties of the right to health care (and specifies some circumstances where non-state actors may owe them).¹⁵⁷ It further specifies that developed nations will have specific duties to assist developing nations fulfill their duties.¹⁵⁸ It articulates which goods are included in the list, avoiding the expansive end of the problem of scope, and updates specific lists of what counts as, for instance, ‘essential medicines,’ thereby avoiding the problem of space and time. The requirement for procedural safeguards for health care allocations above the

requires a sanitation system, the right to health may have non-health care-based systemic elements too.

155. Da Silva, *Realizing the Right to Health Care in Canada*, *supra* note 1; Da Silva, *A Goal-Oriented Understanding*, *supra* note 99, at 379–82.

156. See, e.g., *id.*

157. GC 14, *supra* note 7, ¶¶ 63–65.

158. *Id.* ¶ 40.

minimum floor set out in the WHO's Model List of Essential Medicines,¹⁵⁹ for example, avoids the narrow end of the problem of scope by allowing the required entitlements to go beyond the goods explicitly listed in international laws. The coherence argument above specifies principles for decision-making that help avoid the problem of principles of scope in general; a commitment to normative coherence is itself a principle that helps avoid this third problem.

Even if the claims in the last paragraph were not true, it is notable that the international right to health faces the same problems. Indeed, it likely faces them to an even larger extent since the goods required to fulfill an expansive version of the right are potentially astronomically expensive. A healthy environment will be expensive indeed, and the duty to provide it is even more diffuse than the duty to provide health care. These problems, then, are no worse for the right to health care than for the broader right to health, suggesting that this objection would prove too much, undermining the case for the right to health that clearly exists as a matter of positive international human rights law.

B. *The Nature of Rights Suggests There Cannot Be a Right to Health Care*

The same thing can be said of the second objection one can lodge against the international right to health care, which states that discussing a right to health care misunderstands the nature of rights.¹⁶⁰ This is, in part, a simple restatement and expansion of the argument from the nature of rights above. In short, it says that a right to health care cannot be fulfilled by any candidate duty-holder. Where all rights entail correlative duties, and duties can only exist where they are at least conceivably possible to fulfill, it is difficult to explain how a right to health care can be a right. Yet, again, the duties under an international right to health care are more easily discernible and achievable than a right to health. It is easier to provide insulin than a healthy environment (and easier to measure insulin provision than it is to measure provision of a healthy environment and each country's contribution thereto).¹⁶¹

Moreover, even if we grant that an international right to health care does not fit the traditional claim-right model of rights where rights must have achievable correlative duties, one cannot ignore the fact that international human rights law recognizes a variety of rights that do not fit this model, including the aforementioned rights to health, a healthy environment, and water. International human rights law may have a unique structure for rights that does not fit the traditional model. Even if this

159. *WHO Model List of Essential Medicines, 20th List, supra* note 91.

160. Sreenivasan, *supra* note 11, at 240.

161. Recall that Sreenivasan lodges his argument from the nature of rights against the broader right to health. *Id.*

undermines the moral case for such rights (and I think there is reason to think not all rights must fit that model),¹⁶² it does not undermine the case for a right to health care as a matter of positive international human rights law.

C. *The International Right to Health Care Does Not Appear to Be a Single Right*

This relates to the third possible objection I will address here—namely, that the right articulated in international human rights law appears to be a catchall term for a variety of claims that is not easily discernible as a right to a particular thing, rather than a standalone right. As noted above, the international human right to health care seems to require provision of essential goods, fairness in health care allocation decisions concerning other goods, and a functioning health care system.¹⁶³ These purported entitlements are related, but they are not identical. Once one acknowledges that not all rights fit the traditional model, however, the complex nature of the right to health care is no longer problematic. Indeed, many rights seem to fit this complex form. Again, recall my discussion of the right to water to see how even the structural component of the international right to health care is not unique. If we think this is morally problematic, we can again appeal to international human rights law's general structure and note that positive international human rights law happily acknowledges other non-standard rights as a matter of positive law. Indeed, international human rights law's claim that all international human rights are indivisible actually supports the idea that no international human right is going to have uniquely discernible content and duties. If all rights entail all other rights, each right is going to require the provision of more than just the goods clearly specified in the articulation of each. Each will thus become complex in nature when we fully specify its content. This may leave philosophers unhappy, but it is an entailment of positive international human rights law, and my argument here is limited to the case for a right to health care in positive international human rights law.

D. *The Link between Dignity and Health Care Requires More Evidence*

A fourth objection states that the coherence argument makes the international right to health care remain purely instrumental in nature. Having conceded that health care provision may only weakly correlate with improved health, and a right to health care that is purely instrumental to

162. See Da Silva, *Realizing the Right to Health Care in Canada*, *supra* note 1, ch. 2. A more sustained discussion of this point is the topic of another manuscript on which I am presently working.

163. I make the general case for an alternative structure for rights to health care in Da Silva, *A Goal-Oriented Understanding*, *supra* note 99 .at 385 and in Da Silva, *Realizing the Right to Health Care in Canada*, *supra* note 1, ch. 2 and 3. The work-in-progress in *id.* addresses whether this structure can be generalized.

improved health at a population level will be severely limited, I stated that it is instrumental to achieving dignity without demonstrating the type of strong correlation between access to health care and dignity that would properly ground the right. One may further state that I failed to establish the independent case for the intrinsic value of a right to health care. While I provided standalone textual evidence for the existence of a right to health care in the textual argument above, this objection has merit. It is true that my case for health care as a necessary condition for a dignified life is non-scientific and is instead based on common sense and predictions about how not being able to access medicines, vaccines, and other health care goods, even outside the public health domain, could render one unable to access their other rights. It is also true that this focus on dignity makes the right primarily instrumental.

I do not think this is a problem with my account. One does not need to rehearse social science evidence to make the instrumental case for health care as a means of ensuring dignity, and an instrumental right can still be a right as a matter of international human rights law, particularly where we recognize that all rights are indivisible and will at times be realized as instrumental to other rights. Moreover, this instrumental character of the international right helps constrain the content of the right and avoid the problem of scope. Finally, the procedural components of the right to health care are not instrumental to equality but are non-instrumental *aspects* of equality.

E. *The Indivisibility of Human Rights Could Still Cut Against My Account*

The final objection I will address was highlighted above. The worry that international human rights law fails to recognize a right to health care lingers. The fact that all rights are connected could still easily cut against my argument. An explicitly binding statement that there is a right to health care is lacking in international human rights law. The lack of recognition of an explicit right to health care could be evidence that it must be part of the right to health. If the right to health is going to avoid redundancy, it must provide some unique content to the indivisible mass of international human rights. A right to health care is a clear candidate. After all, rights to most of the other social determinants already exist elsewhere in the legal order. Yet I must admit that there is a textual argument from absence and indivisibility against recognition of an international right to health care. I simply maintain that the other arguments given in favor of it outweigh this argument against it.

CONCLUSION

While international human rights law does not explicitly recognize a right to health care, the texts supporting the international right to health

support recognition of such a right in a way that is not reducible to recognizing such a right only when it is more instrumentally valuable for improving health outcomes at the population level than alternatives. Health care is also necessary for realizing other international rights. So, health care provision is instrumentally necessary for recognition of these other goods. This suggests that there is a health care component to other international rights. International human rights law is thus most coherent where it recognizes a right to health care. This coherence argument is further strengthened by international trade law's recognition of the primacy of health care goods among other intellectual goods: international law as a whole is most coherent when it recognizes health care as a good important enough to ground a right. These arguments for recognition of a right to health care deal with the most damaging critiques of the concept of an international right to health care. Most lingering objections apply equally to the international right to health. There is, then, good reason to acknowledge the existence of an international right to health care as a matter of positive law.