

THE RIGHT TO HEALTH IN INTERNATIONAL LAW: ITS IMPLICATIONS FOR THE OBLIGATIONS OF STATE AND NON-STATE ACTORS IN ENSURING ACCESS TO ESSENTIAL MEDICINE

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ABSTRACT

A range of international human rights instruments, declarations and resolutions affirm that good health is a precondition for the enjoyment of all other human rights and for participation in socio economic and political life. However, many people across the globe (especially in Africa and Asia) lack access to essential medicine. This article argues that access to medication, treatment and care is an essential element of effective responses to pandemics and other diseases. In particular, it is argued that international law imposes a minimum core (and non derogable) obligation on states to provide essential medicine. In recognition of the increasing role that private actors are playing in ensuring access to essential medicine, their human rights obligations relating to access to essential medicine are also explored.

I INTRODUCTION

The Declaration of Alma-Ata correctly proclaims that the attainment of the highest possible level of health is a ‘most important worldwide social goal’.¹ Good health is critical to a decent and dignified life. It is ‘basic to the enjoyment of all human rights and a precondition for participation in social, political and economic life’.² In order to attain and sustain a healthy status, access to health care services and the availability of the underlying preconditions for health are both essential.³ However, many people around the world do not have access to treatment for many

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1 Para I. The Declaration was adopted at the International Conference on Primary Health Care, held in Alma-Ata, USSR (6-12 September 1978).

2 AL Taylor ‘Making the World Health Organisation Work: A Legal Framework for Universal Access to the Conditions for Health’ (1992) 18 *American J of L & Medicine* 301, 311.

3 B Toebes ‘The Right to Health’ in A Aide et al (eds) *Economic, Social and Cultural Rights* (2001) 169, 170.

diseases.⁴ The World Health Organisation (WHO), for example, estimates that one-third of the world's population lacks access to essential medicine in the poorest parts of Africa and Asia.⁵ The HIV/Aids scourge has worsened this problem.⁶ Although the cure for HIV/Aids remains unknown, antiretrovirals have scientifically been proven to be effective in reducing Aids related death rates in high-income countries.⁷ Access to medication, treatment and care is therefore an essential element of an effective response to such pandemics.⁸ It is also critical to respecting the rights of those affected.

The issue of access to essential treatment has also highlighted that actions and decisions of pharmaceutical corporations, research institutions in science and medicine, international financial institutions, multilateral trade institutions and many other non-state actors have an impact on the enjoyment of human rights.⁹ This development means that the realisation of human rights requires the action of many actors other than the state.

This article demonstrates that international law recognises access to essential medicine as a fundamental component of the right to health, binding both state and non-state actors. Furthermore, it argues that the provision of essential medicine constitutes a minimum core obligation of the state. It is therefore the responsibility of states to give effect to these international obligations in the domestic sphere. Part two provides an overview of the developments that led to the recognition of the right to health in international law. Part three examines in considerable detail the meaning of the right to health enshrined under the International Covenant on Economic, Social and Cultural Rights (ICESCR) and other international and regional human rights instruments. The definition of essential medicine and the justiciability of the right to health are also examined in this part. Parts four and five explore the implications of the right to health for state and certain non-state actors respectively in ensuring access to essential medicine.

4 M Bezuhly et al 'International Health Law' (1997) 31 *International Law* 645, 657.

5 WHO *The Rationale of Essential Medicines* (11 November 2002) available at <<http://www.who.int/medicines/rationale/shtml>> .

6 See DP Fidler *International Law and Infectious Diseases* (1999) 197-99. By early 2003, about 42 million people were living with HIV/Aids. 29.4 million of these were from sub-Saharan Africa. In 2002 alone, the epidemic claimed the lives of 2.4 million people from sub-Saharan Africa. UNHCR *Access to Medication in the Context of Pandemics such as HIV/AIDS* (16 January 2003); UNAIDS & WHO *AIDS Epidemic Update: December 2002* available at <http://www.unaids.org/worldaidsday/2002/press/update/epiupdate2002_en.doc> .

7 AIDS Law Project & The AIDS Legal Network *HIV/Aids and the Law: A Resource Manual* (2ed) (2001) 25.

8 UNHCHR (note 6 above) para 5.

9 See generally WHO 'Evolving Public-Private Roles in the Pharmaceutical Sector' A Report of an Informal Consultation, Geneva, Switzerland (15-18 April 1996) available at <http://whqlibdoc.who.int/hq/1997/WHO_DAP_97.10.pdf> .

II THE HISTORICAL ACCOUNT OF THE RECOGNITION OF THE RIGHT TO HEALTH IN INTERNATIONAL LAW

Diseases and illnesses have afflicted humanity since its existence. However, before the eighteenth century the concern for people's health fell outside the scope of state responsibilities.¹⁰ Epidemic diseases were generally considered as a sign of poverty and immorality.¹¹ It was therefore regarded as the responsibility of private actors such as families, churches and charities to care for the sick.¹² The single public effort aimed at containing the spread of epidemic diseases was quarantine of the ill. Attitudes towards treatment of and care for the sick began to change in the eighteenth century. At this time, Western governments began to assume some responsibilities for health care through the establishment and administration of public institutions to care for sick people.¹³ However, it was not until the nineteenth century that the foundations of the modern concepts of public health were laid.¹⁴ The Industrial Revolution was responsible for this change. Firstly, poor and unhealthy working and living conditions, which accompanied industrialisation, revealed that causes of illness extended beyond poor spiritual and moral conditions. Unfavourable social and environmental conditions were also responsible for their occurrence and spread.¹⁵ Secondly, progress in natural sciences during this period resulted in significant discoveries about causes, prevention and treatment of diseases.¹⁶ Thirdly, the need for a more productive and reliable labour force to support industrialisation motivated the assumption by the state of more responsibilities for social welfare of the people including disease control, treatment and prevention.¹⁷ Cumulatively, these factors gave rise to a realisation that expertise and scientific knowledge in health and public action were critical to efforts aimed at containing communicable diseases.¹⁸ Consequently, by the close of the nineteenth century, public health became a societal goal while the protection of health became a public responsibility.¹⁹

A notable development in public health care in the second half of the nineteenth century was a series of International Sanitary Conferences

10 AR Chapman 'Core Obligations Related to the Right to Health and Their Relevance for South Africa' in D Brand & S Russell (eds) *Exploring the Core Content of Socio-Economic Rights: South African and International Perspectives* (2002) 35, 38.

11 SS Fluss 'International Public Health Law: An Overview' in R Detels et al (eds) *Oxford Textbook of Public Health Vol 1* (1997) 371, 376.

12 Chapman (note 10 above) 38.

13 DP Fidler *International Law and Public Health: Materials on and Analysis of Global Health Jurisprudence* (2000) 8.

14 Toebes (note 3 above) 171.

15 Ibid.

16 Fidler (note 13 above) 12.

17 Chapman (note 10 above) 38.

18 Fidler (note 13 above) 10.

19 Ibid 9.

hosted by Western governments. These conferences were triggered by the increase in international commerce and interstate movements of people, which brought to the fore the risk of the prevalence of communicable diseases.²⁰ This risk informed the need for coordinating the prevention of diseases at an international level. Although the major objective of these initiatives was narrow, to protect European states against alien diseases, these conferences reinforced the role of the state as a guarantor of people's health.

Two developments provided the impetus for the recognition of the right to health in the twentieth century.²¹ The first was the great depression of the 1930s, which fuelled calls for social welfare programmes aimed at providing social security to citizens. The second was the Second World War and the horrors of the holocaust. Scientific experimentation on human beings and poor living conditions to which Jews and their sympathisers were subjected projected the issue of health protection to the fore in the aftermath of the World War. It has been submitted that the reference to health in art 55 of the United Nations Charter was a result of a Special Memorandum at the United Nations Conference on International Organisations, which declared that '[m]edicine is one of the pillars of peace'.²²

It is not surprising therefore that the 1946 Constitution of the WHO affirmed that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'. The right to health was later included in the founding document of the international human rights movement, the Universal Declaration of Human Rights (UDHR).²³ It has since been given express recognition in a range of other international and regional treaties and domestic constitutions.

III ACCESS TO ESSENTIAL MEDICINE AND THE RIGHT TO HEALTH

(a) Semantic and conceptual problems in defining the right to health

International human rights instruments have not been consistent in the formulation of the right to health. The result is that what is commonly called the right to health is a mere convenient shorthand expression of the human rights protection of various aspects of health.²⁴ The WHO Constitution, for example, defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or

20 Toebes (note 3 above) 171.

21 Ibid.

22 Ibid.

23 See art 25 of the UDHR.

24 Fidler (note 6 above) 181.

infirmary'.²⁵ This definition presupposes that the state can ensure the complete or good health of an individual. This goal is practically unachievable.²⁶ One's good health is dependent on many variables including actions of other persons, society as a whole and one's own behaviour and habits.²⁷ In fact, nature itself imposes limitations on the attainment of complete physical, mental and social well-being. Other instruments recognise the 'right to health'. This expression is also considered by other writers to be limited in scope because, the argument goes, it purports to exclude health care.²⁸ In view of these concerns, some commentators have suggested the use of the term 'the right to health care' to emphasise the elements of equity and fairness in the provision of medical care.²⁹ Even this expression is amenable to criticism for being too restrictive in that it relates more to provision of medical services than a guarantee of the underlying preconditions for health.³⁰ Furthermore, some have argued, it purports to sanction coercive redistribution of individual resources.³¹ Thus, a broader phrase 'the right to health protection' is sometimes preferred because it encompasses both the right to health care and the right to health conditions'.³²

The following sections will demonstrate that most international and regional human rights instruments explicitly or impliedly converge on the point that the right to health, despite the differences in formulation, consists of both curative and preventive health care services and the protection of the underlying determinants of health such as food, sanitation, safe water, housing, education and clothing. Provision of essential medicines in particular, it will be shown, forms part of the minimum core component of the right to health.

(b) The right to health and access to medicine under the ICESCR

(i) The relevance of the ICESCR

The ICESCR constitutes one limb of the hard law version of the UDHR incorporating what are traditionally called economic, social and cultural

25 See Preamble to the WHO Constitution.

26 D Exter & Hermans 'The Right to Health Care Focussing on Europe' in PJ van Krieken (ed) *Health, Migration and Return: A Handbook for a Multidisciplinary Approach* (2001) 10, 11.

27 Chapman (note 10 above) 39.

28 VA Leary 'Implications of the Right to Health' in KE Mahoney & P Mahoney (eds) *Human Rights in the Twenty-First Century: A Global Challenge* (1993) 481, 484.

29 PJ van Krieken 'The Importance of Adjectives' in Van Krieken (ed) (note 26 above) 17. According to Fidler (note 6 above) 14, 'health care' means the medical services – diagnostic, preventive, therapeutic and rehabilitative – designed to maintain or improve a person's state of health or alleviate a person's suffering. See also K Pillay 'Tracking South Africa's Progress on Health Care Rights: Are We any Closer to Achieving the Goal?' (2003) 7 *Law, Democracy & Development* 55.

30 VA Leary 'The Right to Health in International Human Rights Law' (1994) 1 *Health and Human Rights* available at <<http://www.hsph.harvard.edu/fixcenter/VIN1leary.htm>>.

31 See generally TJ Bole & WA Bondeson *Right to Health Care* (1991).

32 Leary (note 30 above) 486.

rights. Together with the International Covenant on Civil and Political Rights (ICCPR), the three are, collectively, popularly known as the international bill of rights. Since its adoption in 1966, the ICESCR has become a reference point for defining economic, social and cultural rights. Many international and regional human rights instruments and domestic constitutions have been modelled on this instrument as far as economic, social and cultural rights are concerned. Also, the Committee on the ICESCR (CESCR) has adopted a range of general comments, concluding observations in respect of state reports and other statements elucidating the meaning and import of these rights. These sources have proved persuasive in interpreting similar provisions of regional treaties³³ and domestic constitutions. The South African Constitutional Court, for example, has adopted the meaning of 'progressive realisation' and 'available resources' as defined by the CESCR in its interpretation of socio-economic rights provisions in the 1996 Constitution.³⁴ It is therefore worthwhile to consider in more detail the provisions of the ICESCR on the right to health and the pronouncements of the CESCR thereon in order to gain insight into the meaning of the right to health and its implications for state and non-state actors.

(ii) *Definition of the right to health*

Article 12 of the ICESCR is an improved version of art 25 of the UDHR, which provides:

Everyone has *the right to a standard of living adequate for the health and well being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security* in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control (emphasis supplied).

This article treats health and medical care as a component of the right to an adequate standard of living.

Unlike the UDHR, the ICESCR is more specific and recognises health as a separate right from the right to an adequate standard of living. Article 12(1) provides that '[s]tate parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.

Reference to 'the highest attainable standard' is a positive departure from WHO's definition of health as a state of complete health. The

33 For example the African Commission in *The Social and Economic Rights Action Centre and the Centre for Economic and Social Rights v Nigeria* Communication 55 of 1996 (SERAC).

34 See *Government of the Republic of South Africa v Grootboom* 2001 (1) SA 46 (CC) (Grootboom); *Minister of Health v Treatment Action Campaign No 2* 2002 (5) SA 721 (CC) (TAC). However, the Court rejected the notion of minimum core obligations upon giving reasons as to its inappropriateness in the South African context.

ICESCR conceptualisation of health recognises that a state can at most ensure what is achievable taking into account the state's resources, and the individual's natural and socio-economic conditions.³⁵

However, under the ICESCR, the definition of the right to health is not confined to health care alone. Rather, it extends to the underlying conditions for health such as food, nutrition, housing, access to safe and potable water and adequate nutrition, safe and healthy working conditions, and a healthy environment.³⁶ This is important bearing in mind that access to medicine alone may not be sufficient to ensure good health. As the HIV/AIDS pandemic has shown, for example, access to adequate nutrition is critical to the success of antiretrovirals in reducing mother-to-child transmission of the virus.³⁷

In addition to generally guaranteeing the right to the highest attainable standard of health, art 12(2) of the ICESCR specifically enjoins states to take steps to achieve this right progressively by taking measures that suggest that the state has an obligation to provide essential medicine. The first measure relates to provision for the reduction of the stillbirth-rate and of infant mortality and for the health development of the child.³⁸ In the case of HIV/Aids, for example, provision for the reduction of infant mortality would include measures to ensure access to antiretrovirals.³⁹ The second obligation relates to measures for the 'prevention, treatment and control of epidemic, endemic, occupational and other diseases'. Reference to treatment presupposes an obligation to take measures aimed at ensuring access to medicines. As the CESCR has stated, the right to treatment includes

[t]he creation of a system of urgent medical care in cases of accidents, epidemics and similar health hazards, and the provision of disaster relief and humanitarian assistance in emergency situations.⁴⁰

The requirement to control diseases enjoins states, severally and jointly, to, among other duties, 'make available relevant technologies', and implement and enhance immunisation programmes.⁴¹

The third set of measures is even more explicit in its articulation of the duty to provide medicines. State parties are obliged to 'create conditions

35 A number of other international and regional human rights provisions have adopted the formulation of the ICESCR. They include art 24(1) of the Convention on the Rights of the Child (CRC), art 16 of the African Charter on Human and Peoples Rights (African Charter) and art 10 of the Additional Protocol of the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights.

36 CESCR General Comment 14 *The Right to the Highest Attainable Standard of Health (Art 12 of the ICESCR)* (22nd Session, 2000) para 4.

37 See S Khoza 'Reducing Mother to Child Transmission of HIV: The Nevirapine Case' (2002) 3(2) *ESR Review* 2.

38 Art 12(2)(a).

39 S Khoza 'HIV, Infant Nutrition and Health Care' (2002) 2 *Socio-Economic Rights Project Research Series* 1-19.

40 General Comment 14 (note 36 above) para 16.

41 *Ibid* para 16.

which would assure to all medical service and medical attention in the event of sickness'.⁴² The CESCR has stated that this obligation includes:

[T]he provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illness, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care.⁴³

The preceding discussion suggests that the content of the right to health is discernible. Access to treatment forms an essential part of that content.

(iii) The duty to provide essential medicine as a core obligation

As with all socio-economic rights, the right to health under the ICESCR is subject to progressive realisation and resource availability.⁴⁴ These qualifications might give rise to an inference that access to medicine is a right that is incapable of immediate claim. However, the CESCR has warned against such an interpretation. While acknowledging that the qualifications 'progressive realisation' and 'to the maximum of the available resources' are necessary flexibility devices given the practical difficulties surrounding the full realisation of economic, social and cultural rights, the CESCR has stated that art 2(1) establishes 'clear obligations' for states parties to move as expeditiously and effectively as possible towards the full realisation of these rights.⁴⁵ States have an obligation to refrain from taking and implementing 'deliberately retrogressive measures' resulting in the denial of existing rights. Otherwise, such measures would have to be justified fully by reference to all rights recognised in the Covenant in the context of the full use of the maximum available resources.⁴⁶

Significantly, the CESCR has developed the concept of 'minimum core obligations' in order to ensure that economic, social and cultural rights are not interpreted as being entirely programmatic or ideals to be attained. The minimum core concept holds that each state party is obliged to satisfy, at the very least, minimum essential levels of each of

42 See article 12(2).

43 General Comment 14 (note 36 above) para 17.

44 Article 2(1) of the ICESCR provides: 'Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant by all appropriate means, including particularly the adoption of legislative measures'. The CESCR has elaborated on the meaning of the various components of this article in General Comment No 3 *The Nature of States Parties' Obligations (art 2(1) of the ICESCR)* (5th session, 14 December 1990).

45 General Comment 3 (*ibid*) para 9.

46 *Ibid*.

the rights recognised under the Covenant.⁴⁷ The concept is not intended to cripple under-resourced states. While recognising that resource constraints are legitimate limitations on the realisation of these rights, it requires that priority be given to the satisfaction of basic needs of people.⁴⁸ This balance is struck by requiring states pleading resource constraints as a defence to the failure to meet at least the minimum core obligations engendered by economic, social and cultural rights to demonstrate that every effort was made to use all resources that are at their disposal in an effort to satisfy, as a matter of priority, those obligations.⁴⁹

It is noteworthy that the provision of essential medicine and equitable and non-discriminatory access to medical facilities constitutes part of the minimum core obligations engendered by the right to health. According to the CESCR, the following are some of the core obligations on states in respect of the right to health:

- To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups;
- To provide essential drugs, as defined from time to time under WHO Action Programme on Essential Drugs;⁵⁰ and
- To ensure equitable distribution of all health facilities, goods and services.⁵¹

In addition, the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights (Maastricht Guidelines) stipulate that a state party violates the minimum essential level of the right to health if a significant number of its people are deprived of 'essential primary health care'.⁵² As defined by the Alma-Ata Declaration, primary health care includes at least education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunisation against major infectious diseases; prevention and control of locally

47 Ibid para 10.

48 See DM Chirwa 'Minister of Health and Others v Treatment Action Campaign and Others: Its Implications for the Combat Against HIV/Aids and the Protection of Economic, Social and Cultural Rights in Africa' (2003) 9 *East Afr J of Peace & Human Rights* 174.

49 General Comment 3 (note 44 above). See also generally D Bilchitz 'Towards a Reasonable Approach to the Minimum Core: Laying the Foundations for Future Socio-economic Rights Jurisprudence' (2003) 19 *SAJHR* 1.

50 Antiretrovirals such as Nevirapine are included in the World Health Organisation Model List of Essential Drugs (rev December 1999) s 6.4.2.

51 General Comment 14 (note 36 above) paras 43(a), (d)-(e); 44(C).

52 Maastricht Guidelines para 9. The Guidelines were adopted in Maastricht, the Netherlands, on 22-26 January 1997.

endemic diseases; appropriate treatment of common diseases and provision of essential drugs.⁵³

As is the case with all minimum core obligations, the state has the onus of justifying that every effort has been made to use all available resources at its disposal to satisfy those obligations as a matter of priority.⁵⁴ It must be noted, however, that the minimum core obligations listed above are non-derogable.⁵⁵ The implication of this is that, although the state has a margin of discretion with regard to satisfaction of minimum essential levels of other aspects of the right to health on the grounds of resource constraints, such justification would be unacceptable under any circumstances with regard to non-derogable obligations.⁵⁶

In South Africa, the Constitutional Court has rejected a construction of socio-economic provisions under the Constitution that stipulates minimum core entitlements.⁵⁷ However, the Court has suggested that the minimum core concept might be of assistance in considering whether measures taken by the state in the realisation of a given socio-economic rights are reasonable.⁵⁸ Thus, it may still serve a useful purpose in determining whether a programme adopted by the state responds to the needs of those in desperate circumstances and whether it excludes a significant segment of society, both of which are important elements of the reasonableness test.⁵⁹

(c) Other international human rights instruments

The obligation to ensure access to essential medical treatment can be implied from several international human rights instruments other than the ICESCR. Among them is the Convention on the Rights of the Child (CRC). The latter contains one of the most elaborate provisions on the right to health and is, arguably, more explicit and clear than many other treaties in its articulation of the right to health as guaranteeing access to health care and conditions suitable for good health. Article 24(1) of the CRC recognises a general right to health and a specific right to 'facilities for the treatment of illness and rehabilitation of health'. This imposes a specific obligation on state parties to 'strive to ensure that no child is deprived of his or her right of access to such health care services [namely, for the treatment of illness and rehabilitation of health]'. Article 24(2)

53 Ibid para VII(3).

54 General Comment 3 (note 44 above) para 10; General Comment 14 (note 36 above) para 47.

55 General Comment 14 (note 36 above) para 47.

56 Ibid.

57 *Grootboom* and *TAC* (note 34 above).

58 Ibid. For a critique of the Constitutional Court's opinion on the impropriety of the minimum core concept, see S Liebenberg 'South Africa's Evolving Jurisprudence on Socio-Economic Rights: An Effective Tool in Challenging Poverty?' (2002) 6 *Law Democracy and Development* 159; Bilchitz (note 49 above) generally.

59 However, differences still exist between the minimum core concept and the reasonableness test. See Liebenberg (note 58 above) 174-76.

lists a number of measures that states are required to take in order to secure the full realisation of the right to health. From these measures, it is possible to infer an obligation to ensure access to treatment or essential drugs. The measures included are those aimed at, among other things:

- Diminishing infant and child mortality;
- Ensuring the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
- Combating disease and malnutrition, within the framework of primary health care, through, *inter alia*, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking water, taking into consideration the dangers and risks of environmental pollution;
- Ensuring appropriate pre-natal and post-natal care for mothers; and
- Developing preventive health care.

The Convention on the Elimination of All Forms of Racial Discrimination (CERD) also contains provisions recognising the right to health. Article 5(e)(iv) stipulates that states have an obligation to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone to equality before the law in the enjoyment of the right to 'public health, medical care, social security and social services'.

Likewise, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) obligates states to take all appropriate measures to eliminate discrimination in the field of health care in order to ensure, on the basis of equality between men and women, access to health care services, including those related to family planning.⁶⁰ States parties have a further obligation to 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.⁶¹

These instruments establish that the right to health generates a specific obligation to provide and guarantee access to essential medicine and other medical products.

(d) Regional instruments

A variety of regional human rights conventions articulate access to essential medicine as a key element of the right to health. The African Charter guarantees a general right to 'enjoy the best attainable state of

⁶⁰ Article 12(1).

⁶¹ Article 12(2).

physical and mental health'.⁶² It places an obligation on state parties to take the necessary measures 'to protect the health of their people and to ensure that they receive medical attention when they are sick'.⁶³ The African Charter on the Rights and the Welfare of the Child also recognises health as a human right. In art 14(2), it lists measures to be undertaken by the state in the fulfilment of the right to health (entailing a right of access to essential medicine) similar to those of the CRC cited above.

In the European system of human rights, two human rights treaties could be cited as recognising the right to health. They, too, give express or implied recognition to the right of access to curative and preventive treatment. The first is the European Social Charter (1961). Under art 11, contracting parties agree to undertake, either directly or indirectly or in cooperation with public or private organisations, appropriate measures to remove as far as possible the causes of ill-health; to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health and to prevent, as far as possible, epidemic, endemic, and other diseases. In the opinion of the Committee of Independent Experts, compliance with this article can take many forms containing such elements as adequate and generally available public health arrangements that provide proper medical care for the whole community and ensure the prevention and diagnosis of disease; special measures to protect the health of mothers, children and the elderly; general measures aimed at 'the prevention of air and water pollution, protection from radioactive substances, noise abatement, food control, environmental hygiene and the control of alcohol and drugs' – all of which should be funded by the state.⁶⁴

The Charter also recognises the right to social security⁶⁵ and medical assistance.⁶⁶ In terms of art 12(2), the right to social security requires contracting parties to establish or maintain a system of social security. Such a system must be at least equal to that required for the ratification of the International Labour Organisation (ILO) Convention 102 Concerning Minimum Standards of Social Security. The latter establishes minimum norms of medical care services to be provided to categories of people entitled. Furthermore, art 13(1) of the Social Charter requires contracting parties to 'ensure that any person who is without adequate resources and who is unable to secure such resources . . . be granted . . . in the case of sickness, the care necessitated by his condition'. Thus, the Social Charter establishes a strong link between the right to social

62 Article 14(1).

63 Article 14(2).

64 Fidler (note 6 above) 13.

65 See art 12.

66 Article 13.

security and assistance, and the right of access to medicine and other medical products.

Apart from the Social Charter, the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine makes specific reference to the right to health. As the name suggests, this Convention was adopted to protect human rights relating to the application of biology and medicine.⁶⁷ Article 3 of the Convention enjoins state parties, taking into account health needs and available resources, to take the appropriate measures with a view to providing 'equitable access to health care of appropriate quality'.

Likewise, the Inter-American system of human rights recognises access to essential medicine as an important element of the right to health.⁶⁸ The Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights recognised that the right to health should be 'understood to mean the enjoyment of the highest level of physical, mental and social well being'.⁶⁹ In order to ensure the enjoyment of this right, the Convention prescribes obligations of conduct to be undertaken by states. Accordingly, states have the obligation to take the following measures:

- Primary health care, that is, essential health care made available to all individuals and families in the community;
- Extension of the benefits of health services to all individuals subject to the state's jurisdiction;
- Universal immunisation against the principal infectious diseases;
- Prevention and treatment of endemic, occupational and other diseases;
- Education of the population on the prevention and treatment of health problems; and
- Satisfaction of the health needs of the highest risk groups and of those whose poverty makes them most vulnerable.⁷⁰

It is clear from the above that although the various international and regional human rights treaties define the right to health differently, access to essential medicine in particular and access to medical care in general including preventive, rehabilitative and curative treatment form a central part of the right to health. The above discussion has also shown that the duty to provide essential medicines is in fact a minimum and non-derogable core obligation inherent in the right to health.

67 See generally the Preamble.

68 See D Shelton 'Human Rights, Health and Environmental Protection: Linkages in Law and Practice' Background paper for WHO, Health and Human Rights Working Paper Series No 1 (2002).

69 See art 10(1).

70 Article 10(2).

(e) Defining essential medicine

International human rights instruments discussed above and their respective monitoring bodies have not defined the term 'essential medicine'. It is therefore not clear what medicine would qualify to be 'essential' for purposes of complying with the right to health.

However, the origin of this term is traceable to the WHO Model List of Essential Drugs adopted in 1977.⁷¹ This List was adopted upon the request of the World Health Assembly to WHO to assist member states in selecting and procuring essential medicines, assuring good quality and reasonable cost. It has since been revised about 11 times and 156 WHO member states, including all member states of the Southern African Development Cooperation (SADC),⁷² have adopted national medicines lists based on it.⁷³ It can be argued that the adoption of national lists constitutes evidence of state practice and *opinio juris* of a customary international rule that the provision of essential medicine is an essential element of the right to health.

In 1977, the first Expert Committee on the Selection of Essential Drugs defined 'essential drugs' as medicines that 'are of utmost importance, basic, indispensable and necessary for the health needs of the population'.⁷⁴ The Expert Committee amended this definition in 1983 by describing 'essential medicines' as

[t]hose that satisfy the needs of the majority of the population; they should therefore be available at all times in adequate amounts in appropriate dosage forms.⁷⁵

It is not clear what motivated the adoption of the new definition. However, all subsequent Committees endorsed this definition until 1999 when the element of affordability was incorporated. According to this addition, therefore, essential medicines must not only satisfy the health care needs of the majority of the population and be available in adequate amounts and appropriate dosage forms, they must also be available 'at a price that individuals and the community can afford'.⁷⁶

The 1983 definition as revised in 1999 raises several concerns. Firstly, the usefulness of the phrase 'majority of the population' is not clear. Secondly, although the elements of availability and accessibility are

71 Available at <<http://www.who.int/medicines/organization/par/edl/eml.shtml>> .

72 R Loewenson 'Essential Drugs in Southern Africa Need Protection from Public Health Safeguards under TRIPS' available at <<http://www.iprsonline.org/ictsd/docs/Loewenson.pdf>> .

73 However, WHO's list is intended to provide guidance only. It remains the responsibility of each state to develop its own list. This flexibility has been allowed in recognition of the need to consider different situations in the determination of essential medicines.

74 WHO Technical Report Series 615 (1977) 9.

75 See SHARED Inc 'Essential Medicines' available at <http://healthshares.org/global_health/essential_medicines.shtml> .

76 WHO Technical Report Series No 895 (2000) 1.

included in the definition, those of adequate quality and acceptability are not.⁷⁷ In recognition of such concerns, WHO's Secretariat has proposed a new description of the term 'essential medicine' comprising three components, namely, definition, selection criteria, and purpose.⁷⁸ According to this proposal, 'essential medicines are those that satisfy the priority health care needs of the population'.⁷⁹ Such medicines would be selected 'with due regard to disease prevalence, evidence on efficacy and safety, and comparative cost-effectiveness'.⁸⁰ The purpose of these medicines is that they should be 'available within the functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality, and at a price the individual and the community can afford'.⁸¹

The proposed description omits the reference to the ambiguous phrase 'majority of the population' and adds elements of adequacy, quality, accessibility and availability, which the CESCR has employed in defining such socio-economic rights as the right to water, education, food and housing. It is submitted that this expansive definition could be adopted for purposes of interpreting the right to health both by international human rights monitoring bodies and domestic courts.

(f) Justiciability of the right to health

The right to health is a typical economic, social and cultural right. It may therefore be claimed that it is not capable of judicial enforcement. The full recognition of socio-economic rights as justiciable rights has historically met with resistance on the alleged ground that they are different in nature from civil and political rights. The debate around this

77 The CESCR has identified the principles of availability, accessibility, quality and acceptability as forming essential elements of such rights as the right to water, food, health, housing and education. Availability demands that relevant facilities, goods and services, as well as programmes are made available in sufficient quantity within a state party. 'Accessibility' means that the relevant goods and services must be accessible in *sufficient quantity* to all within a state party physically and economically without discrimination. 'Quality' means that the services and goods must be of good quality and/or scientifically and medically appropriate. 'Acceptability' requires that the relevant facilities, goods and services are culturally acceptable, gender sensitive and/or ethically appropriate. See CESCR General Comment 15 (2002) *The Right to Water (arts 11 and 12 of the Covenant)* E/C.12/2002.11 (29th session, 11-29 November 2002) para 12(c)(iii); CESCR General Comment 4 *The Right to Adequate Housing (art 11(1) of the Covenant)* (6th session, 13 December 1991) para 8(d). See also General Comment 14 (note 36 above) para 12.

78 E-Drug 'Description/Definition of Essential Drugs by WHO' available at <<http://www.essentialdrugs.org/edrug/archive/200204/msg00036.php>> .

79 Ibid.

80 Ibid.

81 Ibid.

issue has been adequately addressed elsewhere.⁸² It suffices to mention that international law has since evolved to recognise that all human rights are interdependent, indivisible, and mutually supporting.⁸³ At the international level, significant steps have been taken to subject the rights recognised in the ICESCR to a complaints procedure. To this effect, the Commission on Human Rights adopted a resolution on 22 April 2003 inviting Special Rapporteurs whose mandates deal with the realisation of socio-economic rights to share views on an optional protocol to the ICESCR and to make recommendations to the working group on the said protocol at its next session.⁸⁴ The resolution also requests the working group to report to the Commission at its sixtieth session and make specific recommendations on its course of action concerning the optional protocol.⁸⁵ An optional Protocol to CEDAW, whose catalogue of rights includes a range of socio-economic rights, was adopted on 12 March 1999. Furthermore, the socio-economic rights under the African Charter are justiciable.⁸⁶ *SERAC*⁸⁷ represents an instance where the African Commission found violations of a range of socio-economic rights. The right to health can therefore be enforced judicially at an international level.

More importantly, constitutions adopted after 1989 have increasingly recognised socio-economic rights (including the right to health) as justiciable rights.⁸⁸ In South Africa, for example, the Constitutional Court has held that not only is the negative obligation to respect these rights enforceable judicially, positive obligations are also justiciable.⁸⁹

Access to essential medicine can also be protected under various other

82 S Liebenberg 'Socio-Economic Rights' in M Chaskalson et al (eds) *Constitutional Law of South Africa* (RS 5 1999) ch 41; S Liebenberg 'The Protection of Economic and Social Rights in Domestic Legal Systems' in Eide et al (note 3 above) 55; C Scott & P Macklem 'Constitutional Ropes of Sand or Justiciable Guarantees? Social Rights in a New South African Constitution' (1992) 141 *Univ Pennsylvania LR* 44; D Beetham *Democracy and Human Rights* (1999) 115-35; P De Vos 'Pious Wishes or Directly Enforceable Human Rights?: Social and Economic Rights in South Africa's 1996 Constitution' (1997) 13 *SAJHR* 67; M Craven 'The International Covenant on Economic, Social and Cultural Rights' in R Hanski & M Suksi (eds) *An Introduction to International Protection of Human Rights* (1999) 101-02; E De Wet *The Constitutional Enforcement of Economic and Social Rights: The Meaning of the German Constitutional Model for South Africa* (1996) 40-1.

83 See, for example, art 13 of *The Proclamation of Tehran* Final Act of the International Conference on Human Rights, Tehran UN Doc A/CONF 32/41 (1968); The Vienna Declaration and Programme of Action, adopted by the World Conference on Human Rights UN Doc A/CONF 157/23 (June 1993) Part I para 5.

84 Para 15 of Resolution 2003/18 on 'The Question of the Realisation in All Countries of the Economic, Social and Cultural Rights Contained in the UDHR and the ICESCR, and Study of Special Problems which the Developing Countries Face in their Efforts to Achieve these Human Rights'.

85 *Ibid* para 16.

86 See arts 47; 55 of the African Charter.

87 Note 33 above.

88 For example African Constitutions adopted after 1989. See C Heyns *Human Rights Law in Africa Series 1996 & 1998* (1998).

89 *Grootboom* (note 34 above) paras 34-8; *TAC* (note 34 above) paras 23-5.

human rights such as the right to life and the right to equality. These rights are justiciable in international and domestic law.⁹⁰ The Human Rights Committee (HRC), which monitors the ICCPR, has stated:

The expression 'inherent right to life' cannot properly be understood in a restrictive manner, and the protection of this right requires that States adopt positive measures. In this connection, the Committee considers that it would be desirable for States parties to take all possible measures to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics.⁹¹

It can be implied from this construction that the right to life generates a duty on the state to ensure access to essential medicine and other medical products. The Indian Supreme Court affirmed such a construction in *Samity v State of West Bengal*.⁹² This case held that a claimant had a right to available emergency treatment by virtue of the right to health. According to the Court:

Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the Government in a welfare State . . . Article 21 imposes an obligation on the State to safeguard the right to life of every person. Preservation of human life is thus of paramount importance . . . Failure on the part of a Government hospital to provide timely treatment to a person in need of such treatment results in a violation of his right to life guaranteed under Article 21.⁹³

Aspects of access to medicine may also be covered under the right to equality and the non-discrimination clause. The principle of non-discrimination requires that differentiation among persons must not result in unfair treatment.⁹⁴ Thus, if access to medicine were restricted on grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, a state would be in violation of the prohibition against discrimination. *Hendrika S Vos v The Netherlands*⁹⁵ represents an instance where the link between issues relating to non-discrimination and access to health care services were discernible, albeit in an indirect fashion. The case considered whether the denial of a disability benefit violated art 26 of the ICCPR proscribing discrimination. Toebes has argued that 'although no violation was found, the fact that the HRC tested the denial of a sickness benefit against Article 26 shows its willingness to read social rights into the non-discrimination clause'.⁹⁶

90 For a discussion of cases where the right to health was dealt with under various heads of human rights, see B Toebes 'Towards an Improved Understanding of the International Human Right to Health' (1999) 21 *Human Rights Quarterly* 661, 671-75.

91 UNHRC General Comment 6 on the right to life (16 July 1982) para 5.

92 AIR 1996 SC 2426, 2429.

93 Ibid.

94 S Gruskin & D Tarantola 'Health and Human Rights' in R Detels et al (eds) *The Oxford Textbook of Public Health* (4th ed; forthcoming).

95 Communication 218/1986, UN GAOR, HRC, 44th Session, Supp No 40, 232, UN Doc A/44/40 (29 March 1989).

96 Toebes (note 90 above) 674.

The right to health generally and the obligation to provide (access to) essential medicine particularly are therefore capable of judicial enforcement both directly and indirectly in international and domestic law.

IV OBLIGATIONS OF STATES INHERENT IN THE RIGHT TO HEALTH IN RELATION TO ESSENTIAL MEDICINE

All human rights generate the duties to respect, protect, promote and fulfil on the state. This part discusses the implications of these duties as regards access to essential medicine.

(a) Duty to respect

The duty to respect compels the state to refrain from interfering in the enjoyment of fundamental rights. It also obligates the state to abstain from preventing and impairing access to human rights.⁹⁷ Liebenberg has argued that the phrase 'preventing and impairing' access is broad enough to include policies that result in denial of access to poor communities of the right, rather than simply an interference with the existing access to the right.⁹⁸ By reason of the duty to respect, the state is enjoined 'to respect right-holders, their freedoms, autonomy, resources, and liberty of their action'.⁹⁹

In the context of health, the duty to respect means that the state should desist from limiting equal access to preventive, curative and palliative health services.¹⁰⁰ Thus, denying access to essential medicine or other medical products would constitute a violation of this duty. Access to medicine must also not be limited on the basis of de facto or de jure discrimination.¹⁰¹ The state is enjoined to refrain from marketing unsafe drugs.¹⁰² It is further enjoined to refrain from deliberately withholding or misrepresenting information vital to treatment or the use of the medicine.¹⁰³ The state would be in violation of the duty to respect if it adopts legislation or policies or suspends them so that the enjoyment of the right to access essential medicine is interfered with.¹⁰⁴ Failure to take into account its legal obligations regarding this right when entering into bilateral or multilateral agreements with other states, international organisations and other entities such as multinational corporations would also amount to a violation of this duty.¹⁰⁵

97 *Grootboom* (note 34 above) para 34.

98 S Liebenberg 'Socio-Economic Rights' in M Chaskalson et al *Constitutional Law of South Africa* (forthcoming 2004).

99 *SERAC* (note 33 above) para 45.

100 General Comment 14 (note 36 above) para 34.

101 *Ibid.*

102 *Ibid.*

103 *Ibid.*

104 *Ibid* para 50.

105 *Ibid.*

(b) Duty to protect

The duty to protect summons the state to take positive action to protect citizens from damaging acts that may be perpetrated by private actors. Accordingly, the state has the duty to ensure equal access to health care (including essential medicine) provided by third parties.¹⁰⁶ It also has an obligation to ensure that third parties do not limit people's access to information relating to essential medicine. Where the service is privatised, the state must ensure that the privatisation '*does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities*'.¹⁰⁷ The state is further enjoined, among other things:

to control the marketing of medical equipment and medicines by third parties; and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct.¹⁰⁸

The duty to protect also requires that vulnerable groups be given special protection. In relation to people with disabilities, for example, the CESCR has stated:

In a context in which arrangements for the provision of public services are increasingly being privatised and in which the free market is being relied upon to an ever greater extent, it is essential that private employers, private suppliers of goods and services, and other non public entities be subject to both non discrimination and equality norms in relation to persons with disabilities.¹⁰⁹

The state discharges the duty to protect through 'the creation and maintenance of an atmosphere or framework by an effective interplay of laws and regulations' to enable individuals to freely realise their rights and freedoms.¹¹⁰ It has to establish 'an effective regulatory system' providing for 'independent monitoring, genuine public participation and imposition of penalties for non-compliance'.¹¹¹ Adoption of legislation is not exhaustive of the state's duty to protect citizens from violations by third parties. Administrative, economic, social, political and other measures must compliment legislation. In accordance with the principle of economic accessibility, the CESCR has stated, for example, that 'tenants should be protected by appropriate means against unreasonable rent levels or rent increases'.¹¹² It is arguable that the state is also enjoined to protect its citizens from unreasonable prices of essential medicine.

106 Ibid para 35.

107 Ibid.

108 General Comment 14 (note 36 above) para 35.

109 CESCR General Comment 5 *Persons with Disabilities* (11th session, 9 December 1994) para 11.

110 *SERAC* (note 33 above) para 46.

111 General Comment 15 (note 77 above) para 24.

112 General Comment 4 (note 77 above) para 8(c).

The duty to protect citizens from violations of a range of socio-economic rights by private actors was enforced in the *SERAC* case.¹¹³ The plaintiffs complained, among other things, that the state-owned Nigerian National Company, and Shell Petroleum Development Corporation had been depositing toxic wastes into the local environment and waterways in Ogoniland in Nigeria without putting in place necessary facilities to prevent the wastes from spilling into villages. As a result, water, soil and oil contamination brought about serious short-term and long-term health problems such as skin infections, gastrointestinal and reproductive complications. Further allegations were made relating to repressive measures such as the destruction of food sources, homes and villages by the military aimed at quelling opposition to the oil companies' activities. The Ogoni communities were neither consulted in the decisions that affected the development of their land nor did they benefit materially from the oil exploration. The African Commission found the Nigerian Government in violation of the rights to health, a satisfactory environment, shelter and housing, food, and life, and of peoples to freely dispose of wealth and natural resources, for its own acts and omissions and for those of the oil companies. It found that the government had breached the duty to protect the people from damaging acts of the oil companies by failing to control and regulate the activities of these companies and allowing them to deny or violate these rights with impunity.¹¹⁴

(c) Duty to fulfil

The duty to fulfil encompasses the duty to promote.¹¹⁵ The latter enjoins the state to ensure that individuals are able to exercise their rights and freedoms through promoting tolerance and raising awareness.¹¹⁶ The duty to fulfil entails an obligation to facilitate the actual realisation of the right.

As part of discharging this obligation, the state must give sufficient recognition to the right to health in its domestic legal system.¹¹⁷ Furthermore, the state has

to ensure the appropriate training of doctors and other medical personnel, the provision of a sufficient number of hospitals, clinics and other health related facilities, and the

113 Note 33 above. For a review of the case, see DM Chirwa 'Toward Revitalising Economic, Social and Cultural Rights in Africa: Social and Economic Rights Action Centre and the Centre for Economic and Social Rights v Nigeria' (2002) 10 *Human Rights Legal Brief* 14.

114 Other cases in which this duty was enforced include *Yanomani v Brazil* Resolution 12/85 *Annual Report of the Inter-American Commission on Human Rights* (1985); *Guerra v Italy* ECHR Judgment of 19 February 1998, Reports of Judgments and Decisions 1998-1 No 64; *Hopu & Bessert v France* UN Doc. CCPR/C/60/D549/1993.

115 The duty to fulfil entails the obligations to 'facilitate, promote and provide'. General Comment 15 (note 77 above) para 25.

116 *SERAC* (note 33 above) para 46.

117 General Comment 14 (note 36 above) para 36.

promotion and support of the establishment of institutions providing counselling and mental health services with due regard to equitable distribution throughout the country.¹¹⁸

Health insurance systems play a critical role in accessing treatment and medicine. The state is obliged by the duty to fulfil to provide for a public, private or mixed health insurance system, which is affordable to all.¹¹⁹

This obligation also requires the state to adopt positive measures that enable and assist individuals and communities to enjoy the right in question.¹²⁰ Additionally, the duty to fulfil includes an obligation to provide the right when individuals or groups are unable to realise the right by their own means.¹²¹

V OBLIGATIONS OF PRIVATE ACTORS

(a) The emerging challenge to the public/private divide

The concept of human rights has traditionally been applied to relations in the public sphere but not to those in the private sphere.¹²² This divide is traceable to liberal thought, which distinguished between matters that fell within the public and private domains. The former consisted of relations between unequal parties, the state and the individual. Human rights evolved to protect the weaker party, the individual, from the heavy hand of the state. By contrast, the private domain concerned relations between individuals who were considered to be free, equal and autonomous. Human rights were therefore irrelevant to these relations.¹²³

The state centric application of human rights is increasingly being challenged. It has been argued, among other things, that the public/private divide constitutes a smokescreen for concealing violations of human rights by non-state actors. Feminist writers have been foremost in advancing this critique, contending that much violence and discrimination against women occurs within the private sphere.¹²⁴ Additionally, private actors have increasingly claimed part of the role of the state in the provision of goods and services.¹²⁵ Privatisation of the provision of

118 Ibid.

119 Ibid.

120 Ibid para 37.

121 Ibid.

122 R Murray *The African Commission on Human and People's Rights and International Law* (2000) 37.

123 A Cockrell 'Private Law and the Bill of Rights: A Threshold Issue of 'Horizontalty' in *Bill of Rights Compendium* (2001) 3A-3; A Cockrell 'Can You Paradigm? Another Perspective on the Public Law/Private Law Divide' (1993) *Acta Juridica* 227ff.

124 A Clapham *Human Rights in the Private Sphere* (1993) 219; K Engle 'After the Collapse of the Public/Private Divide: Strategising Women's Rights' in D Dellemeyer (ed) *Reconceiving Reality: Women and International Law, American Society of International Law* (1993) 995; E Scheinider 'Violence of Privacy' (1992) 23 *Connecticut LR* 973, 974.

125 See M Monshipouri & CE Welch 'The Search for International Human Rights and Justice: Coming to Terms with the New Global Realities' (2001) 23 *Human Rights Quarterly* 373.

health services is an example through which the state has ceded part of its sovereignty. Some private actors such as multinational corporations and international financial institutions also exercise considerable control on states and their policies relating to health.¹²⁶ In particular, decisions and policies of pharmaceutical corporations, private employers, insurance companies, medical aid societies and other actors have a significant bearing on accessibility of drugs.¹²⁷ These developments do not only mean that human rights are liable to violations by the non-state actors but also that state action can no longer be sufficient to guarantee human rights. They have sustained calls for the recognition of the horizontal application of human rights.¹²⁸

As a result of this call, corporations have increasingly adopted corporate codes of conduct in preference to binding human rights obligations.¹²⁹ This has not prevented human rights activists and academics from agitating for binding norms. Although the dominant view remains that the principal objective of international law is to regulate inter-state relations, recent studies in international human rights law suggest that it is possible for private actors to bear human rights obligations. For example, two comprehensive studies by the International Council on Human Rights Policy into various international and regional treaties, declarations and other documents on human rights reveal that these sources, expressly or by implication, do in fact recognise direct and indirect obligations of non-state actors, contrary to the dominant view that human rights bind the state only.¹³⁰

Indirect responsibility of private actors for human rights is arguably more entrenched in international law. This type of responsibility arises through the exercise by the state of the obligation to protect citizens. The discharge of the duty to protect may require private actors to refrain from interfering in the enjoyment of socio-economic rights as well as to take action to enhance their enjoyment. Unlike direct responsibility, indirect obligations of non-state actors can be enforced through the state. *SERAC*

126 See RBJ Walker & SH Mendlovitz 'Interrogating State Sovereignty' in RBJ Walker & SH Mendlovitz (eds) *Contending Sovereignties: Redefining Political Community* (1990) 1 cited in H Steiner & P Alston *International Human Rights in Context* (1996) 151; D Türku 'The Realisation of Economic, Social and Cultural Rights' Final Report submitted by UN Special Rapporteur, E/CN.4/Sub.2/1992/16; SI Skogly *The Human Rights Obligations of the World Bank and the International Monetary Fund* (2001) 17-26.

127 See S Joseph 'Pharmaceutical Corporations and Access to Drugs: The "Fourth Wave" of Corporate Human Rights Scrutiny' (2003) 25 *Human Rights Quarterly* 425.

128 See P Gonidec 'Towards a Treatise of African International Law' (1997) 9 *Afr J Int and Comp L* 807, 813.

129 J Pace 'The Global Compact - Fact or Fiction?' (2003) 7 *Mediterranean J of Human Rights* 127.

130 International Council on Human Rights Policy *Beyond Voluntarism: Human Rights and the Developing International Legal Obligations of Companies* (2002); International Council on Human Rights Policy *Taking Duties Seriously: Individual Duties in International Human Rights Law, a Commentary* (1999).

discussed above represents an example where such obligations were enforced.¹³¹

It is also possible to imply direct obligations in the preamble to the UDHR, for example, which provides that 'every individual and every organ of state . . . shall strive . . . to secure' the universal and effective recognition and observance of all human rights. This statement suggests that private actors have not only the obligation to respect human rights but also the duty to take positive steps to ensure their realisation.¹³² Several other human rights instruments such as the CRC, the African Charter, the African Convention on the Rights and Welfare of the Child, impose duties directly on such private actors as individuals, children, parents and communities.¹³³ Some of these duties relate to socio-economic rights and entail both positive and negative aspects. Significantly, the ICESCR expressly declares that the individual is under a responsibility to strive for the promotion and observance of the rights recognised under it. The CESCR has stated unambiguously that 'all members of society – individuals, families, local communities, non-governmental organisations, civil society organisations, as well as the business sector have responsibilities in the realisation of the right to food'.¹³⁴ The ILO has perhaps broken more ground than any other international human rights body in imposing direct obligations on non-state actors, especially in relation to labour rights.¹³⁵ Although not always explicit, these instruments and many others not specifically mentioned here can be construed to imply that private actors have both negative and positive obligations in relation to socio-economic rights.¹³⁶ At the moment, direct obligations of private actors in relation to socio-economic rights are not amenable to any of the orthodox enforcement mechanisms in international law such as state reporting and the complaints procedure.

However, significant progress is being made regarding the recognition of enforceable human rights obligations of private actors. In the United States, actions against private actors for violations of international human rights law can be brought under the Alien Tort Claims Act. Although most cases relate to violations of civil and political rights, the

131 Note 33 above.

132 See generally International Council on Human Rights Policy (2002) n 130.

133 Ibid.

134 CESCR General Comment 12 *The Right to Adequate Food (art 11 of the Covenant)* (20th session, 12 May 1999) para 20.

135 See C Scott 'Multinational Enterprises and Emergent Jurisprudence on Violations of Economic, Social and Cultural Rights' in Eide et al (note 3 above) 563, 568-74. Some of the instruments adopted under the auspices of the ILO call upon multinational companies to: Create employment opportunities; promote equality; ensure security of employment; provide favourable conditions and work place safety; and protect freedom of association and the right to organise in host countries.

136 DM Chirwa 'Non-State Actors' Responsibility for Socio-Economic Rights: The Nature of their Obligations under the South African Constitution' (2002) 3(3) *ESR Review* 2.

facts of some of them establish clear violations of socio-economic rights.¹³⁷ In Canada, England, Spain and Australia, similar litigation is taking place.¹³⁸ Several African Constitutions such as those of South Africa (1996), Malawi (1994), the Gambia (1996), Cape Verde (1990), Ghana (1992), and Mali (1992) have explicitly recognised the horizontal application of their Bills of Rights.¹³⁹ These developments render the possibility of enforcing both direct and indirect obligations of non-state actors more real at the domestic level.

(b) The nature of the obligations of private actors implicit in the right of access to essential medicines

The nature of the obligations of private actors are still unclear given that the horizontal application of human rights is still a novel idea. However, it can be argued that private actors are at the very least bound by the duty to respect the right to health. In *Grootboom*, the Constitutional Court held, in the context of the right of access to adequate housing, that there exists 'at the very least, a negative obligation upon the state and *all other entities and persons* to desist from preventing or impairing the right to access to adequate housing'.¹⁴⁰ In *TAC*, the Constitutional Court found the state to be in a violation of the negative aspect of the right to health because, among other things, its policy had the effect of limiting access to Nevirapine by pregnant mothers residing outside the few pilot sites.¹⁴¹ By extension, it can be argued that private actors have the duty to refrain from interfering with availability, quality, accessibility and acceptability of essential medicine. Private health providers, in particular, have the duty to respect the principle of confidentiality.

It can also be argued that private actors are bound by the non-discrimination clause. As mentioned above, the CESCR has stated, in relation to people with disabilities, that 'it is essential that private employers, private suppliers of goods and services, and other non-public entities be subject to both non-discrimination and equality norms in relation to persons with disabilities'.¹⁴² In South Africa, for example, private actors are bound by non-discrimination and equality norms.¹⁴³ It can therefore be argued that private actors, such as private health providers, medical aid societies, pharmaceutical companies, insurance

137 DM Chirwa 'Obligations of Non-State Actors in Relation to Socio-Economic Rights under the South African Constitution' (2003) *Mediterranean J of Human Rights* 29, 51.

138 *Ibid* 52-3.

139 *Ibid* 49.

140 *Grootboom* (note 34 above) para 34 (emphasis supplied).

141 Note 34 above.

142 General Comment 5 (note 109 above) para 11.

143 See s 9(4) of the Constitution of the Republic of South Africa Act 108 of 1996 and, generally, the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000. It must be noted that 'socio-economic status' is listed as a prohibited ground of discrimination in this Act.

companies and private employers are enjoined to refrain from adopting policies or taking any measures that result in discrimination of people as regards access to essential medicine. A private employer or medical aid society would be in violation of this duty if it restricted access to medical aid on grounds of race, birth, political or other opinion, origin or any other known ground of discrimination.

In discharging the obligation to refrain from interfering with quality, availability, acceptability and accessibility, it is conceivable that private actors may be bound to take positive action. By extension, it is arguable that pharmaceutical companies are enjoined to produce medicines that are culturally acceptable, scientifically appropriate and of good quality. Likewise, private health care providers have the obligation to employ qualified medical personnel, not to market unexpired drugs, and to acquire appropriate health equipment. In keeping with the principle of accessibility, private actors have the obligation to provide the relevant information regarding essential medicine and other health issues.

As mentioned earlier, the CESCR has stated that 'tenants should be protected by appropriate means against unreasonable rent levels or rent increases'. By implication the state would also be bound to protect people from unreasonable price increases of essential medicine. A further implication of the CESCR's statement is that private actors have an indirect obligation to refrain from imposing unreasonable charges for essential medicine or services related to it.

VI CONCLUSION

Access to essential medicine is a fundamental component of the human right to health. As a minimum and non-derogable core, states cannot claim resource constraints as a reason for non-compliance with the obligation to ensure, protect and facilitate access to the right to essential medicine. The right to health is justiciable directly or indirectly through other rights and generates three levels of duty on the state. Firstly, the state has the duty to respect this right. This means that the state should abstain from interfering with or limiting access to essential medicine. It must not suspend measures aimed at giving effect to the right to health. The state must also consider fully its international obligations when entering into agreements with states and other actors that have an effect on access to essential medicine. Secondly, the state has the duty to protect people from acts of third parties that can lead to a denial of access to essential medicine. For example, the state has the duty to regulate private actors to ensure that availability, accessibility, quality and acceptability of medicine and services incidental to its access are not interfered with. Lastly the state has the duty to fulfil the right to health. Accordingly, the state is bound to raise awareness on this right, give sufficient recognition of the right in its domestic system, ensure the training of personnel, provide sufficient health related facilities and provide a health insurance

system which is affordable to all. The duty to fulfil also requires the state to provide a safety net for those that cannot afford essential medicine on their own.

This article has also argued that the public/private divide is increasingly being challenged and that international law and domestic legal systems are moving towards the recognition of binding obligations of private actors. This development is encouraging given that actions of private actors have a significant impact on access to essential medicine. Although the precise obligations of private actors are still unclear, this article has contended that private actors have the obligation to respect the right to health. It has also been argued that certain private actors have the duty, among others, to respect the confidentiality principle when dealing with patients, to refrain from imposing unreasonable charges for essential medicines and services related to it, to provide the necessary information relating to essential medicine, not to discriminate, and to ensure quality of essential medicine.