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Citation:

FILHO, Luciano (2024). Interpreting the international right to health in global health priority-setting (or what lies beyond a fair procedure). Journal of Global Health Law, 1 (2), 203-228. [Article]

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Interpreting the international right to health in global health priority-setting (or what lies beyond a fair procedure)

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Journal of Global Health Law (1) 2, December 2024.

Global health actors and local governments face enduring challenges to respond to a wide range of health needs. Given the competing priorities in health, Lie maintains that non-discrimination is the only legal principle that could apply to resource allocation, as all human rights can provide is the obligation to do “something” about access to health, without designating what.[1] Since the right to health under international law does not provide a way out for conflicting health claims, determining priorities often falls within the purview of health economics and medicine, in a fair accountable process.[2]

Under this view, rather than relying on legally authoritative sources in international law, the content of the right to health in global health may be highly influenced by a theory of justice in health known as "accountability for reasonableness".[3] Instead of establishing general criteria for what to prioritise, this ethical model proposes a set of conditions to ensure a fair deliberative process to arrive at such decisions, such as public participation, transparency and the opportunity to revise decisions. So entrenched is this theory in global health that numerous scholars would concur that the allocation of resources pertaining to the right to health hinges, to a large degree, on issues of fair procedure.[4] Substantive entitlements within priority-setting have been traditionally overlooked, and despite some recent suggestions to incorporate social values other than cost-effectiveness, human rights scholars may conflate pure fair procedure guarantees with the right to health.[5]

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[1] Reidar K Lie, ‘Health, Human Rights and Mobilization of Resources for Health’ (2004) 4 BMC International Health and Human Rights 4.

[2] Laura Niada-Avshalom, ‘Some Scepticism on the Right to Health: The Case of the Provision of Medicines’ (2015) 19 The International Journal of Human Rights 527, 531-532,540.

[3]See Norman Daniels, *Just Health: Meeting Health Needs Fairly* (Cambridge University Press 2007).

[4] See e.g. Benedict Rumbold and others, ‘Universal Health Coverage, Priority Setting, and the Human Right to Health’ (2017) 390 The Lancet 712; Sofia Gruskin and Norman Daniels, ‘Process Is the Point: Justice and Human Rights: Priority Setting and Fair Deliberative Process’ (2008) 98 American Journal of Public Health 1573; Audrey Chapman, ‘The Foundations of a Human Right to Health: Human Rights and Bioethics in Dialogue’ (2015) 17 Health and Human Rights 6.

[5] See e.g. Daniel Wei Liang Wang, ‘Priority-Setting and the Right to Health: Synergies and Tensions on the Path to Universal Health Coverage’ (2020) 20 Human Rights Law Review 704; Sofía Charvel and others, ‘Challenges in Priority Setting from a Legal Perspective in Brazil, Costa Rica, Chile, and Mexico’ (2018) 20 Health and Human Rights 173.

In this article, I aim to explain further the normative role of the right to health in priority-setting under international law, as laid out by the International Covenant on Economic, Social and Cultural Rights (ICESCR).[6] To support this study, I conduct a comparative analysis of sources relevant to the right to health in international law that can guide priority-setting in global health. My analysis leads to the conclusion that the right to health involves more than just addressing resource distribution considerations through a fair accountable process. It also requires imposing positive obligations to reduce the impact of resource constraints from the outset, alongside ensuring a fair process in priority-setting. In short, I propose to reclaim the original essence of the right to health by turning to traditional economic and social rights frameworks in international law, considering fundamental obligations that determine the realisation of such rights. The right to health exists to drive resource mobilisations towards priorities, as much as setting those priorities in a fair procedure. It may be brought into play to defy political economy issues behind rationing health by integrating both resource mobilisation and progressive realisation as forms of standards within priority-setting decisions.[7]

Accordingly, the response to the COVID-19 pandemic illustrates priority-setting and resource mobilisation interdependent and interrelated relationship. On the one hand, the need to control a contagious disease with the specific requirements of a novel coronavirus was not thoroughly defined by previous instruments and demanded coordination that had never been formulated on such a large scale, including the development of a vaccine and the supply of ventilators.[8] On the other hand, governments overcame unprecedented challenges by thinking creatively and seeking alternatives to maximise resources to live up to these new priorities: swift set-up of low-cost pre-built or converted hospital rooms, accelerating the production of ventilators, or coordinating procurement strategies to secure enough vaccines.[9] This approach does not completely eliminate the need for priority-setting through accountable decision-making, but it significantly improves progressive realisation by preventing avoidable forms of scarcity. The right to health standards, as advanced here, are less concerned with

[6] Art. 12, ICESCR.

[7] Amy Kapczynski, 'The Right to Medicines in an Age of Neoliberalism' (2019) 10 Humanity: An International Journal of Human Rights, Humanitarianism, and Development 79, 79–80.

[8] See e.g. Lisa Montel and others, 'The Right to Health in Times of Pandemic: What Can We Learn from the UK's Response to the COVID-19 Outbreak?' (2020) 22 Health and Human Rights 227. Dainius Pūras and others, 'The Right to Health Must Guide Responses to COVID-19' (2020) 395 The Lancet 1888; Kathleen Liddell and others, 'Who Gets the Ventilator? Important Legal Rights in a Pandemic' (2020) 46 Journal of Medical Ethics 421; Ezekiel J Emanuel and others, 'Fair Allocation of Scarce Medical Resources in the Time of Covid-19' (2020) 382 New England Journal of Medicine 2049.

[9] See e.g. Frederick M Abbott and Jerome H Reichman, 'Facilitating Access to Cross-Border Supplies of Patented Pharmaceuticals: The Case of the COVID-19 Pandemic' (2020) 23 Journal of International Economic Law 535; Carlos López-Gómez and others, 'COVID-19 Critical Supplies: The Manufacturing Repurposing Challenge' (*UNIDO*, 2020) <https://www.unido.org/news/covid-19-critical-supplies-manufacturing-repurposing-challenge> accessed 1 September 2021; Simiao Chen and others, 'Fangcang Shelter Hospitals: A Novel Concept for Responding to Public Health Emergencies' (2020) 395 The Lancet 1305.

pre-determining local priorities (which can vary among jurisdictions and specific realities over time) and more focused on how particular priorities will be achieved. Such strategic interventions undertaken by States include better intellectual property frameworks, price negotiation, and other market regulations representing "legal determinants of scarcity".[10]

To arrive at the proposed explanation, I contrast three analytical approaches in terms of selected sources applicable to resource allocation in health. I will survey them through a tiered interpretation from the most basic norms in economic and social rights to a wider range of sources in international law: at first level, as the preferred position, by considering the basic rules related to resource allocation in the ICESCR applicable to all economic and social rights; at second level, by exploring the scope of priorities set out in the soft-law guidance from the Committee on Economic and Social Rights (CESCR); and lastly, by aggregating all sources in Global Health Law at large.

The first and defended reading has the practical effect of a continuous commitment to finding resources and protecting against unnecessary rationing, even though it cannot alone indicate priorities (consistent with the procedural approaches in local priority-setting). This can be referred to as the *basic resource generation approach* derived only from treaty obligations. It considers the essential ICESCR textual provisions of Article 2.1, in bringing together the rules of maximum availability of resources and progressive realisation of rights, both assessed by the reasonableness doctrine. These obligations guarantee that the limitation of resources is not permanently used to legitimise the automatic denial of economic and social rights.

Section 1 will explore why the procedural approach to resource allocation remains a central aspect of global health discourse and why more effort is needed in looking deeper into the obligations established under the ICESC. Section 2 provides a necessary reminder of the intrinsic values of economic and social rights. It introduces the basic resource generation approach, which operates under a foundational set of principles challenging the notion of scarcity to facilitate the development and advancement of healthcare access. This approach synthesises the concepts of progressive realisation and resource mobilisation, which involve substantive State policies integrated into priority-setting procedures. In Section 3, the first iteration of goal-oriented prioritisation within the framework of the right to health, I explore normative guidance for various public health objectives outlined by the CESCR. Section 4 turns to the potential guidance provided by various sources linked to the right to health within the realm of Global Health Law. Ultimately, the conclusion is that the first approach adds significant value to local priority-setting while preserving the legitimacy of local deliberations. These obligations require states to pursue alternative policies to mitigate scarcity wherever possible, alongside any priority-setting decision.

[10] Luciano Bottini Filho, 'The Legal Determinants of Scarcity: Expanding Human Rights Advocacy for Affordability of Health Technologies' (2023) 25 Health and Human Rights 205.

1. The need for more in-depth doctrinal investigation of the right to health in priority-setting

Before assessing appropriate readings of the right to health in priority-setting under international law, I will first clarify in which ways the procedural discourse still prevails over principles concerning economic and social rights. Despite its widespread acceptance, the fair procedure ideal is borrowed from philosophical and bioethical developments and is not explicitly grounded in human rights legally authoritative enouncements (nothing close to accountability for reasonableness is said, for instance, in General Comment 14 on the right to health).[11] Yet, procedural approaches have been seen as problematic for various reasons such as difficulty to operationalise them or their lack of substantive moral orientation, despite human rights scholarship never truly engaging with these criticisms.[12]

In this scenario, two main issues may be observed: first, there is only tangential engagement with core economic and social rights principles, which will be reviewed in turn in later sections. Second, there is a continuous conflation of fair procedure with the right to health obligations when studying State implementation of this right instead of considering State obligations.

Regarding the first problem, it must be acknowledged that significant efforts have been made to develop priority-setting beyond accountability for reasonableness by integrating more substantive values. However, human rights discussions remain very limited. A timely contribution to this subject in global health is the development of "evidence-informed deliberative processes (EIDP)", aimed at coupling procedural aspects with substantive values. Nevertheless, authors refer to such frameworks vastly on procedural grounds.[13] Where present, those substantive values are not, necessarily, a faithful correspondence to international law obligations, and they may be framed as questions of equity, fairness or solidarity.[14] In addition, commentators on EIDP may display distrust of human rights and describe them as a threat to fair deliberations, in particular with litigation.[15] Even in works critical of excessive use of cost-effectiveness analysis, such as offered by Ottersen et al, human

[11] Committee on Economic, Social and Cultural Rights, General Comment No. 14, UN Doc. E/C.12/2000/4 (2000).

[20] Keith Syrett, 'Health Technology Appraisal and the Courts: Accountability for Reasonableness and the Judicial Model of Procedural Justice' (2011) 6 Health Economics, Policy and Law 469, 472.

[13] See e.g. Rob Baltussen, Maarten Jansen and Wija Oortwijn, 'Evidence-Informed Deliberative Processes for Legitimate Health Benefit Package Design – Part I: Conceptual Framework' [2021] International Journal of Health Policy and Management 1.

[14] Wija Oortwijn and Philip Klein, 'Addressing Health System Values in Health Technology Assessment: The Use of Evidence-Informed Deliberative Processes' (2019) 35 International Journal of Technology Assessment in Health Care 82.

[15] Kalipso Chalkidou and others, 'Health Technology Assessment: Global Advocacy and Local Realities Comment on "Priority Setting for Universal Health Coverage: We Need Evidence-Informed Deliberative Processes, Not Just More Evidence on Cost-Effectiveness"' (2016) 6 International Journal of Health Policy and Management 233, 234.

rights considerations as to resource mobilisation are not raised directly.[16] Some scholars, in establishing commonalities between the right to health and priority-setting, often neglect resource mobilisation obligations, unless very vaguely referring to the requirement of appropriately funded health systems.[17] In this way, they do not discuss important factors bearing upon resource allocation, such as access policies and systemic market reforms, in the manner proposed, for instance, by the Office of the United Nations High Commissioner for Human Rights.[18]

Similarly, recent guidance on priority-setting from the World Health Organisation (WHO) may omit human rights obligations as to resource mobilisation.[19] For instance, the emphasis is to describe the right to health as not contradicting to "the selection of some technologies and exclusion of access to others", as well to "good governance and management of public finances", so that it is supportive and differential to fair procedures.[20]

The second persistent problem is that of researchers investigating procedural elements in resource allocation as a central proxy to the right to health or its ideal interpretation with no serious attention to resource mobilisation.[21] DiStefano et al considered whether judicial interpretation of the right to health in South Africa (SA) embraces accountability for reasonableness. Similarly, this procedural approach has been used to measure human rights standards in priority-setting bodies in Latin America.[22] Drawing on the same procedural view, Wang evaluated the relationships between Universal Health Coverage (UHC) and the right to health (as if they were correspondent) strictly from the angle of priority-setting procedures.[23]

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[16] Trygve Ottersen and others, 'The Future of Priority-Setting in Global Health' in Ole F Norheim, Ezekiel J Emanuel and Joseph Millum (eds), *Global Health Priority-Setting* (1st edn, Oxford University PressNew York 2019).

[17]Rumbold and others (n 4).

[18] Office of the United Nations High Commissioner for Human Rights, Analytical study on key challenges in ensuring access to medicines, vaccines and other health products in the context of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/HRC/56/28) 2 July 2024, paras 44-66

[19] See e.g. David Clarke, Gwenaël Dhaene and John Lisman, 'Legal Considerations: Reviewing or Establishing the Legal Framework.' in Melanie Bertram, Gwenaël Dhaene and Tessa Tan-Torres Edejer (eds), *Institutionalizing health technology assessment mechanisms: a how to guide* (World Health Organization 2021); WHO, 'Ethics and COVID-19: Resource Allocation and Priority-Setting' <https://www.who.int/ethics/publications/ethics-covid-19-resource-allocation.pdf?ua=1> accessed 6 June 2020.

[20] Clarke, Dhaene and Lisman (n 20) 20–21.

[21] Wang (n 5).

[22] Charvel and others (n 5).

[23] Wang (n 5).

With this in mind, it is not an understatement to infer that procedural approaches remain central to global health debates today. Scarcity is treated as almost an inevitable condition that cannot be reversed within priority-setting through human rights advocacy. In the following section, I will demonstrate how economic and social rights have a different relationship to resource allocation and, through the framework provided by the ICESCR, priority-setting can be reenvisaged and coupled with ideals of resource maximisation and progressive realisation of access to health.

2. The basic economic and social rights stance on scarcity

To explore the most fundamental principles of resource allocation in international human rights, I will begin by highlighting the inherent nature of economic and social rights, particularly in relation to economic policies, budgets, and resources. This sets them apart from the procedural approaches often employed in global health regarding the right to health. International economic and social rights challenge the notion of scarcity, which underpins the interpretative model presented here. These rights under the ICESCR were not conceived with the belief that resource constraints are unsurmountable. Instead, they were intended to push the State to progress and address the root causes of scarcity. For instance, in response to the scarcity in hospitals in Colombia, the Committee on Economic, Social and Cultural Rights (CESCR), the ICESCR human-rights treaty-body, recommended that the State "intensify its efforts to allocate sufficient resources" and also suggested implementing appropriate tax reforms to reduce inequalities and increase "the resources available for the implementation of economic, social, and cultural rights."[24] Other concluding observations of the Committee maintain the same rationale for recognising scarcity but also demand targeted actions and structural policy changes.[25]

This is a fundamental outlook, in contrast to the belief that human rights have entrenched neoliberalism and do no more than guarantee minimum levels of subsistence to support market functioning. [26]Despite their potential to rebalance market power, it has been argued that human rights have achieved little in this regard.[27] This may

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[24] CESCR, “Concluding observations on the sixth periodic report of Colombia” 19 October 2017 (E/C.12/COL/CO/6), paras 19-20, 61-62.

[25]See e.g. CESCR, “Concluding observations on the combined second to fourth periodic reports of Egypt”13 December 2013 (E/C.12/EGY/CO/2-4), para 21; Concluding observations on the combined third, fourth and fifth periodic reports of El Salvador, 19 June 2014 (E/C.12/SLV/CO/3-5) paras 21-23.

[26] John Linarelli, Margot E Salomon and Muthucumaraswamy Sornarajah, *The Misery of International Law: Confrontations with Injustice in the Global Economy* (Oxford University Press 2018) 255–66.

[27] See some of the accounts of the common origins of neoliberalism and human rights: Jessica Whyte, *The Morals of the Market: Human Rights and the Rise of Neoliberalism* (Verso Books 2019); Samuel Moyn, ‘A Powerless Companion: Human Rights in the Age of Neoliberalism’ (2014) 77 Law & Contemporary Problems. 147; Umut Ozsu, ‘Neoliberalism and Human Rights: The Brandt Commission and the Struggle for a New World’ (2018) 81

be true to a certain degree, however, if there is anything the 2008-09 economic crisis could teach us, it is that economic and social rights can be promoted against austerity to generate solutions rather than surrendering to market forces.[28] This developing "new paradigm" of human rights calls for substantial State intervention, with a rekindled interest in implementing and institutionalising human rights-based approaches (HRBA) in economic policies or reducing inequality. [29] Among various alternatives to scarcity, human rights scholars have appealed to taxation, monetary policies, market regulation and alternative instruments to support budgets or bankroll the public debt.[30]

Thus, while not always successful, economic and social rights may stand against neoliberal ideology in favour of the private market and support the welfare state and healthcare spending.[31] Since this reinvigorated attention to economic and social rights as market transformative devices, human rights have been associated with "constructive" or "expansive" visions of resources and scarcity, such as progressive realisation, maximum available resources, non-retrogressive measures and proportionality, as per Article 2.1. of the ICESCR.

In times of crisis, different to the discourse in global health of prioritisation and difficult choices, ICESCR obligations demanded alternatives and exceptional measures for additional resources.[32] The growth-focused economic and social rights standards were further developed in the 2010 response to successive global

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Law & Contemporary Problems 139; Joseph R Slaughter, 'Hijacking Human Rights: Neoliberalism, the New Historiography, and the End of the Third World' (2018) 40 Human Rights Quarterly 735, 765–69.

[28] See e.g. David Bilchitz, 'Socio-Economic Rights, Economic Crisis, and Legal Doctrine' (2014) 12 International Journal of Constitutional Law 710; Aoife Nolan (ed), *Economic and Social Rights after the Global Financial Crisis* (Cambridge University Press 2014); Markus Krajewski, 'Human Rights and Austerity Programmes' in Christian Tietje, Rosa M Lastra and Thomas Cottier (eds), *The Rule of Law in Monetary Affairs: World Trade Forum* (Cambridge University Press 2014); Julia Dehm, 'Righting Inequality: Human Rights Responses to Economic Inequality in the United Nations' (2019) 10 Humanity: An International Journal of Human Rights, Humanitarianism, and Development 443, 453–54. Radhika Balakrishnan, James Heintz and Diane Elson, *Rethinking Economic Policy for Social Justice: The Radical Potential of Human Rights* (Routledge 2016) 28–41.

[29] Matthias Goldmann, 'Contesting Austerity: Genealogies of Human Rights Discourse' [2020] Max Planck Institute for Comparative Public Law & International Law (MPIL) Research Paper 35–44. Rodrigo Uprimny Yepes and Sergio Chaparro Hernández, 'Inequality, Human Rights, and Social Rights: Tensions and Complementarities' (2019) 10 Humanity: An International Journal of Human Rights, Humanitarianism, and Development 376, 387–89.

[30] Magdalena Sepúlveda Carmona, 'Alternatives to Austerity: A Human Rights Framework for Economic Recovery' in Aoife Nolan (ed), *Economic and Social Rights after the Global Financial Crisis* (Cambridge University Press 2014) 25–30.

[31] Audrey R Chapman, *Global Health, Human Rights and the Challenge of Neoliberal Policies* (Cambridge University Press 2016) 92–102.

[32] David Birchall, 'Human Rights and Political Economy: Violations and Realization Under Global Capitalism' [2021] SSRN Electronic Journal 11–15 <http://dx.doi.org/10.2139/ssrn.3780591> accessed 5 May 2021; Ann Blyberg and Helena Hofbauer, *Article 2 and Governments' Budgets* (International Budget Partnership 2014) 2 <https://www.internationalbudget.org/publications/escrarticle2/> accessed 21 February 2021.

recessions.[33] In 2012, to warn States of their obligations under the Covenant, the CESCR advised that restrictions should be:

1. A temporary measure, covering only the period of the crisis,
2. Necessary and proportionate,
3. Non-discriminatory and should mitigate inequalities that can grow in times of crisis (including through tax measures to support transfers to the most marginalised)
4. It [the State] should identify and protect the 'minimum core content' or 'social protection floor' (as defined by the ILO) of the rights and ensure the protection of this core content at all times.[34]

Despite being far from a direct condemnation of capitalism, the CESCR turned its attention to inequality, unfair tax policies and the need to obtain resources through international cooperation to fulfil human rights duties.[35] More recently, human rights bodies (including the CESCR) have adopted a fairly nonconformist interpretation of the role of economic and social rights during the COVID-19 pandemic.[36] It follows that, despite finite resources, this category of rights displays some growing resistance to scarcity to pursue higher levels of human rights enjoyment.

2.1 Focusing on the State's conduct in priority-setting

Now that I established what drives economic and social rights in resource allocation, let me turn to the nature of the obligations engaged within priority-setting in this context. The progressive stance of these rights against scarcity is based on key principles set out in the ICESCR, Article 2.1. In this subsection, it is maintained that the treaty text provides principles to determine which substantive conducts are forms of implementation of the

[33] Jernej Letnar Černič, 'The European Court of Human Rights, Rule of Law and Socio-Economic Rights in Times of Crises' (2016) 8 Hague Journal on the Rule of Law 227, 234–43.
[34] CESCR, "An Open Letter" 16 May 2012 (CESCR/48th/SP/MAB/SW).

[35] Aoife Nolan, 'Not Fit for Purpose? Human Rights in Times of Financial and Economic Crisis'(2015)' 4 European Human Rights Law Review 358. See Warwick on the relaxation of the non-retrogressive doctrine and the avoidance to deal with non-retrogression obligations after the financial crisis: Ben TC Warwick, 'Socio-Economic Rights during Economic Crises: A Changed Approach to Non-Retrogression' (2016) 65 International & Comparative Law Quarterly 249; Ben TC Warwick, 'A Hierarchy of Comfort? The CESCR's Approach to the 2008 Economic Crisis' in Gillian MacNaughton and Diane F Frey (eds), *Economic and Social Rights in a Neoliberal World* (Cambridge University Press 2018) 143–46.

[36] See e.g. CESCR, 'Statement on the Coronavirus Disease (COVID-19) Pandemic and Economic, Social and Cultural Rights', 6 April 2020 (E/C.12/2020/1) paras 13, 17, 19, 21; European Committee of Social Rights, 'Statement of Interpretation on the Right to Protection of Health in Times of Pandemic', statement (Strasbourg, 21 April 2020), pp. 3–6, https://rm.coe.int/statement-of-interpretation-on-the-right-to-protection-of-health-in-ti/16809e3640, accessed in 20 December 2020.

right to health in resource allocation. This approach combines the rules on maximum available resources, progressive realisation, and the reasonableness standard to identify conducts to prevent scarcity where possible. Economic and social rights have obligations of "conduct" (State action towards a priority) or "result" (the priority itself). Result obligations are measured by a definite outcome, while conduct obligations are complied with by determined acts or moves, towards a result to be fulfilled.[37] Where States are unable to secure full implementation of a determined health priority, the alternative is to focus on resource generation conducts.

Thus, the key idea is that States must undertake specific conducts to seek the resources and measures that make progressive realisation of outcomes possible.[38] These conducts are policies that should be implemented alongside resource allocation (e.g., reducing taxes on medical imports to ensure affordability) to secure the outcomes. Since priorities can only be established within a specific context and timeframe, the focus should not be on deriving priorities solely from the right to health (results). Instead, it should be on enforcing the essential practices that are crucial for advancing towards local health priorities as ultimate results.

Yet, there is much ambiguity surrounding conducts and results as international obligations. The International Law Commission (ILC), in the context of State responsibility, has concluded that obligations of means were related to specific conducts or omissions, and results were to be valued by outcomes only.[39] The effect was to leave wide 'wriggle room' for States to decide on their course of action to meet the obligation of result, while obligations of conduct allow no other path than the specified conduct.[40]

Overall, a hybrid approach to conducts and results is more suitable to achieving economic and social rights realisation through "taking steps" (conducts), but also to securing results, conditions permitting.[41] Despite the importance of conducts to mobilise resources, it is quite common to assume that economic and social rights

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[37] The contentious point here is whether economic and social rights oblige specific conducts or multiple courses of actions. See Guy S Goodwin-Gill, 'Obligations of Conduct and Result' in Paul Alston and Katarina Tomasevski (eds), *The Right to Food* (Martinus Nijhoff 1984) 112–113.

[38] Langford and King present an overview of the conduct/result dispute see: Malcolm Langford and Jeff A King, 'Committee on Economic, Social and Cultural Rights' in Malcolm Langford (ed), *Social Rights Jurisprudence* (Cambridge University Press 2009) 483–86

[39] See Roberto Ago, 'Document A/CN.4/302 and ADD.1-3 (Sixth Report on State Responsability)' (1977) II Yearbook of the International Law Commission 3.

[40] Ibid

[41] Eibe Riedel, Gilles Giacca and Christophe Golay, 'The Development of Economic, Social, and Cultural Rights in International Law' in Eibe Riedel, Gilles Giacca and Christophe Golay (eds), *Economic, Social, and Cultural Rights in International Law: Contemporary Issues and Challenges* (Oxford University Press 2014) 18. Compare also the example of the Convention on the Elimination of Racial Discrimination, joining the two obligations : Rudiger Wolfrum, 'Obligations of Result Versus Obligations of Conduct' in Mahnoush H Arsanjani and W Michael Reisman (eds), *Looking to the future: essays on international law in honor of W. Michael Reisman* (Martinus Nijhoff Publishers 2011) 380–381.

obligations always correspond to results, as this has been argued to be the practice of the CESCR, despite the typology not being uniformly referenced.[42] The Committee itself could not establish a sharp division between the two, since General Comment 14 accepts both forms of obligation, without declaring which of the Convention's obligations correspond to each category or both.[43] This ambiguity is fraught with an almost circular reasoning to isolate conducts from results, which would be a "more than futile, if complex, exercise", as Sepulveda warns.[44]

Therefore, in resource allocation, it can be assumed that conduct obligations prevail when results cannot be immediately executed – States have an obligation of result when they have resources, if not, they must take steps (obligations of conduct). Alston and Quinn advocate this understanding, whereby determining conducts (steps) is the only immediately realisable obligation in economic and social rights.[45] Fukuda-Parr et al. also maintain that outcomes alone are insufficient to measure state compliance; instead, the focus should be on the conduct, especially when circumstances are beyond the government's control.[46] When a State fails to achieve results, it must at least take obligatory and concrete "steps" proportionate to its capacity.[47] The main question rests upon how to discern what are the appropriate steps so as to make more resources available during allocation. Among the many possibilities are price regulation of healthcare products and services, taxation, price control, patent pooling, enforcement of competition regulation, public-private partnerships, international purchase cooperation, and resort to intellectual property flexibilities.[48]

Those measures are specific to local conditions and the nature of the health good to be attained, and no single set of conducts can be devised or anticipated without particular attention to the healthcare need concerned

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[42] See e.g. David Beetham, 'What Future for Economic and Social Rights?' (1995) 43 Political Studies 41, 49.

[43] CESCR, "General Comment No. 3: 'The nature of States parties' obligations' (GC 3)" 14 December 1990 (E/1991/23), para. 1. Comments in Lisa Forman and others, 'Conceptualising Minimum Core Obligations under the Right to Health: How Should We Define and Implement the "Morality of the Depths"' (2016) 20 The International Journal of Human Rights 531, 538.

[44] Magdalena Sepúlveda Carmona, *The Nature of the Obligations Under the International Covenant on Economic, Social and Cultural Rights* (Intersentia 2003) 195.

[45] Philip Alston and Gerard Quinn, 'The Nature and Scope of States Parties' Obligations under the International Covenant on Economic, Social and Cultural Rights' (1987) 9 Human Rights Quarterly 156, 165–166.

[46] Sakiko Fukuda-Parr, Terra Lawson-Remer and Susan Randolph, *Fulfilling Social and Economic Rights* (Oxford University Press 2015) 22.

[47] See e.g. how "steps" are viewed as results in General Comment No. 3: "The principal obligation of result reflected in article 2(l) is to take steps 'with a view to achieving progressively the full realisation of the rights recognised'", Manisuli Ssenyonjo, 'Reflections on State Obligations with Respect to Economic, Social and Cultural Rights in International Human Rights Law' (2011) 15 The International Journal of Human Rights 969, 977.

[48] See Bottini Filho (n 10).

(this is different from normal obligations of conducts described by the ILC, as the conducts are not predetermined). If no measures are possible, then there is no immediate necessity of result. Attention to conducts departs considerably from a "violation approach" to economic and social rights. Since what is measured are the efforts to realise human rights and mobilise resources, it is much more a question of violation by omission than by State action, as described in the typology proposed by Chapman and endorsed by the Limburg Principles (a statement made by an expert group in the Netherlands in 1980) and some decisions of the Committee.[49]

A violation approach requires the commission of acts "as policies or laws that create conditions inimical to the realisation of recognised rights".[50] It is established by (1) violations resulting from actions and policies of governments; (2) violations related to patterns of discrimination; and (3) violations related to a state's failure to fulfil the minimum core obligations of enumerated rights.[51] This classification refers to positive actions and omissions in such a way that conducts and progressive realisation would not actually occur in practice. To implement some health policies, States must undertake conducts of resource mobilisation to accomplish obligations of result. During progressive realisation, the primary obligations lie more on undertaking certain conducts, such as in market regulation, than to not interfering with rights (excluding healthcare for certain groups) or directly fulfilling an obligation of result (establishing a health service). Although there is not a list of specific conducts to achieve obligations of result, some general principles that identify conducts States should undertake are set out in Article 2(1) ICESCR, which reads:

> Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

This is a very intricate Article, but two main concepts stand out: maximum availability of resources and progressive realisation.[52] Because not all priorities can be immediately achieved, progressive realisation and maximum availability of resources are two immediate conduct obligations in resource allocation. As the Article emphasises "adoption of legislative measures", conducts consisting only of legislative measures (as in market

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[49] Audrey R Chapman, 'A Violations Approach for Monitoring the International Covenant on Economic, Social and Cultural Rights' (1996) 18 Human Rights Quarterly 23, 43.

[50] Id.

[51] Chapman, 'A Violations Approach for Monitoring the International Covenant on Economic, Social and Cultural Rights' (n 50) 43.

[52] Matthew CR Craven, *The International Covenant on Economic, Social, and Cultural Rights: A Perspective on Its Development* (Clarendon Press 1998) 151; Ssenyonjo (n 48) 974.

regulation) may likely be regarded as immediately realisable obligations for not being contingent on existing resources yet being used to generate more resources.[53]

Further, such State conducts must be towards a legitimate obligation of result within the right to health in keeping with the general principles of the ICESCR and aforementioned Article 2 (1). Just as the Covenant is silent on the list of appropriate conduct obligations in resource mobilisation, it is broad and vague on the possible health priorities that must be fulfilled by the State as obligations of result. The Covenant enumerates programmatic results that should be taken for the full realisation of the right to health, but with no hierarchy.[54] Every step should fall within this broader list, but the actual conduct of States in complying with these obligations is subject to the method of assessment of the implementation of economic and social rights (progressive realisation/maximum available resources).

The next three subsections will examine the practical effects of each principle that determines State conducts in resource allocation to make local health priorities achievable. After exploring the two principles outlined in Article 2(1)—maximum available resources and progressive realisation—the reasonableness standard will be incorporated to help define the substantive policies necessary for health priority-setting.

2.3 Maximum Available Resources

In resource allocation, the principle of maximum available resources aids in determining the required level of resource mobilisation for economic and social rights realisation. In general, the CESCR has understood this level of resources to be contextual with local capacities.[55] The idea of maximum available resources can be contradictory since “maximum" is the deal; while "available" is the reality, as Robertson reminds us.[56] However, no matter what the level of resources, the obligation to maximise their availability is considered of immediate effect (so States must always resort to all possible means).[57] For some, resources would be the existing financial means at the disposal of a government, for others, they could simply be the resources that a State potentially

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[53] Langford and King (n 39) 486–489.

[54] ICESCR (n 30) Art. 12.: It sets outs the following targets: “a) reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; b) improvement of all aspects of environmental and industrial hygiene, c) prevention, treatment, and control of epidemic, endemic and occupational diseases, d) conditions to assure all medical care for the sick”.

[55] See Craven (n 53) 136. Craven bases his view on Badawi El Sheikh, E/C.12/1989/SR.7.

[56] Robert E Robertson, ‘Measuring State Compliance with the Obligation to Devote the Maximum Available Resoures to Realizing Economic, Social, and Cultural Rights’ (1994) 16 Human Rights Quarterly 693, 694.

[57] Rodrigo Uprimny, Sergio Chaparro Hernández and Andrés Castro Araújo, ‘Bridging the Gap: The Evolving Doctrine on ESCR and “Maximum Available Resources”’ in Katharine G Young (ed), *The Future of Economic and Social Rights* (Cambridge University Press 2019) 629.

can avail itself of contained in all the economy and wealth existing in an entire jurisdiction (natural resources, human capital, technologies, incremental fiscal policies, etc.)[58]

To make economic and social rights more effective, the notion of resources must be wider and not a mere slice of the budget that can only be expanded by more expenditure. Resources are to be interpreted in a far broader manner, including the power of the State to mobilise resources by non-financial means or to exercise its regulatory capacity to make the necessary material goods for healthcare more accessible or less costly.[59] The portfolio of measures proposed by treaty-bodies and experts revolves around traditional macroeconomic market interventions concerning fiscal, monetary and budget policies to mobilise potential resources.[60]

The more restrictive the notion of resources, the lower the onus of economic and social rights on the State. If resources are just the current financial capacity of a State, a State would be allowed to indefinitely allocate the same level of resources to comply with the right to health. The creation of resource availability can sometimes be construed strictly as a form of money transfer (either internationally through external State assistance, in an early opinion held by treaty-bodies, and now through taxation, as developed by experts and in the general comments after the 2008-9 financial crisis).[61] Kendrick adopts this view when proposing a method of determining the expected level of resources for the right to health under a particular economic situation by discussing only financial resources. [62] However, this approach cannot quantify the level a State can reach through efficiency in utilising its political and non-financial resources to reduce costs or expand the availability of healthcare. Economic and social rights can steer economic policy decisions and regulation of private actors that would not be achieved without the State.[63]

The Committee has so far only partially developed a doctrine to measure additional resources that can be availed by each country, concentrating on tax policies and lost revenue. Uprimny et. al. propose some key points of

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[58] Radhika Balakrishnan and Douglass College, 'Maximum Available Resources & Human Rights: Analytical Report' (Center for Women's Global Leadership 2011) 2, CRC, Day of General Discussion on 'Resources for the Rights of the Child – Responsibility of States', 46th session, 21 September 2007 (CRC/C/46/CRP.1), para. 24.

[59] Robertson (n 58) 704–713.

[60] For instance, Balakrishnan et. al examine the creation of resources for human rights reviewing : "(1) government expenditure; (2) government revenue; (3) development assistance (both official development assistance and private resource flows); (4) debt and deficit financing; and (5) monetary policy and financial regulation": Balakrishnan and Douglass College (n 60) 5.

[61] Ibid.

[62] Abby Kendrick, 'Measuring Compliance: Social Rights and the Maximum Available Resources Dilemma' (2017) 39 Human Rights Quarterly 657, 669–678.

[63] Wiktor Osiatynski, *Human Rights and Their Limits* (Cambridge University Press 2009) 136–137.

analysis which draw on some of the interpretations of the Committee (such as the presumption that resources were insufficiently employed where core obligations are violated or corruption as evidence of improper use of resources).[64] Though there are still difficulties in determining the failure to use all available resources in a non-financial sense, an emerging doctrine of maximum available resources, as described by Uprimny, is consolidating.

2.4 Progressive realisation

As resources are mobilised, progressive realisation comes into operation.[65] Non-compliance with progressive realisation may be found where there have been no more rights-related investments over an extended period, despite economic growth.[66] Steps should be constantly implemented and the condition of progressivity should not be argued to continuously stall compliance.[67] Hence, under the Covenant, States are not only obliged to make efforts to their maximum ability but also to uninterruptedly seek to go further through progressive realisation. Under the Limburg Principles, it is not fundamental that more resources are employed, as long as there is an expeditious expansion of the realisation of rights with a focused programme: "The obligation of progressive achievement exists independently of the increase in resources; it requires effective use of resources available".[68] Effective, in this sense, means the actual application of all available resources (which do not necessarily need to be financial, as with "societal resources").[69]Therefore, non-economic resources may also be taken into account when developing policies that enhance the enjoyment of rights in a country, including regulatory State powers such as price controls.

Priority-setting can, to some extent, identify more effective interventions, but it alone may not ensure greater access to health without simultaneously addressing economic constraints as broader regulatory measures may. In a manner analogous to progressive realisation, the ICESCR also introduces the "Right to Continuous Improvement of Living Conditions" under Article 11(1).[70] This right requires ongoing efforts to enhance the

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[64] Uprimny, Chaparro Hernández and Araújo (n 59) 649–653.

[65] Ssenyonjo (n 48) 977; Eva Brems, 'Human Rights: Minimum and Maximum Perspectives' (2009) 9 Human Rights Law Review 349, 365.

[66] See e.g. CESCR, "Concluding observations: Angola", 1 December 2008 (E/C.12/AGO/CO3) para. 20.

[67] Shareen Hertel and Lanse Minkler, 'Economic Rights: The Terrain' in Shareen Hertel and Lanse Minkler (eds), *Economic Rights: Conceptual measurement and policy issues* (Cambridge University Press 2007) 17.

[68] Cornelis Flinterman, '"Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights" (1987)' 9 Human Rights Quarterly 122.

[69] Ibid, art. 24.

[70] Article 11(1), ICESCR (note). See comments on:

enjoyment of rights through effective resource mobilisation. The idea of progressive realisation is not just a deliberative procedure to rearrange a health system for cost-effectiveness but an obligation to forge ahead continuously finding solutions for financial constraints by effective usage of any other available resource.[71] This contrasts with the interpretation advanced by global health scholars, who claim that the minimum basket of health services offered to the majority of the population – known as Universal Health Coverage (UHC) – has its progressive realisation ensured by public accountability and setting priorities around the most cost-effective interventions.[72] This progressive realisation as a procedure presupposes identifying priorities without heeding efforts to expand the budget or intervening in structural policies that maximise available resources, rather than simply reallocating them. If a health system needs reorganisation and has sufficient funds, that could be enough to redistribute the coverage in a manner that would satisfy equity considerations and population needs. Conversely, if there are structural barriers related to insufficient funding or inadequate market regulation that depend on extra efforts, a procedure would generally not remedy the unavailability or unaffordability of some healthcare services.

A problem with progressive realisation is that it does not define in itself what the State conducts that should permanently be pursued. Because there is more than one single method to achieve a higher level of enjoyment of rights, this principle does not alone indicate the right pathway of progress, which could vary according to the local reality or the order of obligations pursued.[73] Jacobs argues for a dialogical and cooperative interpretation of progressive realisation, taking into account all stakeholders – from NGOs, international bodies, governments and civil society – that build this notion according to the local constraints and priorities .[74]

Despite that, with the doctrine of reasonableness, international law already provides a framework for interpreting Covenant obligations that can help assess what is the scope of State conducts for progressive realisation, as discussed in the next subsection. Reasonableness contributes to defining a range of acceptable actions based on the State's circumstances, which should guide substantive policies related to resource mobilisation, progressive realisation, and priority-setting. Since progressive realisation must be combined with the requirement for maximum available resources, a more inclusive interpretative approach to substantive policies is needed for rights realisation, rather than merely accepting that a fair procedure is the sole reasonable

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[71] Rob Baltussen and others, 'Progressive Realisation of Universal Health Coverage: What Are the Required Processes and Evidence?' (2017) 2 BMJ Global Health e000342, 6. Compare with Lisa Forman, 'Decoding the Right to Health: What Could It Offer to Global Health?' (2015) 8 Bioethica Forum 7, 93.

[72] Baltussen and others (n 73) 2–5.

[73] On progressive realisation's lack of concreteness, see: Lesley A Jacobs, 'Adapting Locally to International Health and Human Rights Standards: An Alternative Theoretical Framework for Progressive Realisation' in MR Madsen and G Verschraegen (eds), *Making Human Rights Intelligible: Towards a Sociology of Human Rights* (Hart 2013).

[74] ibid.

conduct.[75]This robust approach to reasonableness regarding specific local health priorities asks what conducts can be feasibly undertaken if the State is truly committed to exhausting all possible forms of policies (maximum available resources) by interfering with the market and without reducing other services.

2.4 Defining State conduct within priority-setting: The Role of strong reasonableness

The reasonableness standard sets the boundaries of progressive realisation and maximum available resources against scarcity. As a legal doctrine, reasonableness has, per se, a degree of deference to the State and should provide a list of programmes that a particular government could adopt until an obligation is satisfied, while not determining a preferred course of action regarding health policies. As described by Arosemena, reasonableness is a means to provide an "adverbialisation" of conducts, meaning that it can qualify efforts that are appropriate to transcend scarcity.[76] The argument is that reasonableness places on the State the burden of confronting scarcity where it is avoidable and proves that economic deficiency is the final justification for non-compliance with the progressive realisation of rights. Under international economic and social rights, reasonableness should not be confused with its narrow scope under other branches of international law or philosophy of law.[77] Both are related to providing justification or rationales (which would be deemed reasonable). Scarcity could be one of those arguments admitting rationing below maximum resources, but it is argued here that the full potential of reasonableness is not simply to accept scarcity in a static and resigned manner: priority-setting will need to be conducted in coordination with access policies, such as price negotiation, better procurement models or compulsory license to ensure that prices are competitive or at an affordable level.

In comparison to other ICESCR provisions, reasonableness has a weaker basis. It is not found in the original treaty, but in the Optional Protocol to the Covenant, which inaugurated an individual complaint mechanism to the monitoring system.[78] This standard resulted from long negotiations in the drafting of the protocol when some state parties were not sufficiently convinced that the oversight of the treaty obligation would not create

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[75] Gustavo Arosemena, *Rights, Scarcity, and Justice: An Analytical Inquiry Into the Adjudication of the Welfare Aspects of Human Rights* (Intersentia 2014) 109.

[76] Ibid, 99-101.

[77] For an overview of reasonableness under international law, see: Olivier Corten, 'Reasonableness in International Law', *Max Planck Encyclopedias of International Law* (Oxford University Press) <https://www.oxfordbibliographies.com/view/document/obo-9780199796953/obo-9780199796953-0127.xml> accessed 27 July 2019.

[78] UN General Assembly, 'Optional Protocol to the International Covenant on Economic, Social and Cultural Rights' 10 December 2008 (A/RES/63/117).

undue interference in domestic affairs.[79] An alternative standard of review in the debates was the proposal of emphasising the margin of appreciation of States to determine the measures required to implement the Covenant, but that also instilled the fear that the new mechanism would be significantly restricted.[80]

Additionally, little has been published on defining the true meaning of reasonableness and how to operationalise it in terms of identifying and mobilising resources for the right to health. Tobin observes that "international law accommodates the reality of the need for states to prioritise the allocation of scarce resources, provided a state is able to demonstrate that the process for allocating these resources can be shown to be reasonable".[81] However, Tobin examines reasonableness only as to rationing and cost-containment and does not touch upon what could be deemed reasonable as concomitant policies to scarcity or make the market more accessible to patients. Tobin's conceptual inventory enumerates only the observance of human rights principles (as set out by the CECSR, and in particular non-discrimination), evidence-based medicine, and accountability conventions that are akin to Daniels' model described (in a type of process) as being "consultative, participatory, transparent and evaluative".[82] Reasonableness, to Tobin, is an extended version of accountability for reasonableness where the relevant criteria are determined both by medical expertise and human rights principles.

As to linking reasonableness with progressive realisation and resources in health, a most successful attempt would be from Perehudoff et al. who proffer a complete framework that addresses the value of reasonableness to counter scarcity.[83] Perehudoff et al. present a more comprehensive view of reasonableness by directly aligning the principles of maximum available resources and progressive realisation with indicators of reasonable measures. These indicators include duties such as mobilising resources, seeking low-cost alternatives, and obtaining external assistance (e.g., price reductions and intellectual property mechanisms). This conceptualisation of reasonableness focuses primarily on implementing the obligation of access to medicines, rather than on resource allocation alone. Their perspective is significant because it departs from the common understanding that scarcity hinders reasonable government measures and that resource allocation under the right to health is confined to procedural aspects without necessitating budget expansion. The authors challenge the adequacy of resources and the State's ability to marshal additional funds and implement policies that effectively address scarcity.

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[79] Brian Griffey, 'The "Reasonableness" Test: Assessing Violations of State Obligations under the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights' (2011) 11 Human Rights Law Review 275, 301.

[80] ibid.

[81] John Tobin, *The Right to Health in International Law* (Oxford University Press 2011) 226.

[82] ibid 237.

[83] Katrina Perehudoff and Lisa Forman, 'What Constitutes "Reasonable" State Action on Core Obligations? Considering a Right to Health Framework to Provide Essential Medicines' (2019) 11 Journal of Human Rights Practice 1, 9–16.

For them, the focus on the distribution of resources, evading other measures:

> "is akin to questioning whether the host has fairly divided the cake among expectant partygoers before asking if the cake was in fact made large enough to satisfy all celebrants. Not to explore the options to maximise resources and leverage efficiencies would be a disservice to the government's capacity to realize rights and to those who stand to benefit from more targeted and efficient use of resources".[84]

However, a concern that can be raised when invoking a reasonableness standard relates to the domestic courts that originally developed it and their deference to policy-makers. Such an approach may be termed a weak form of reasonableness. In a weak approach, a mere formal assessment of reasonableness would rest on considering procedural aspects of the decision, the governance of the policies and whether the rationale was appropriate to pursue a goal, without discussing the content of the right.[85] Consequently, priority-setting decisions are evaluated solely on the basis of how the decision-making process took place, focusing on participation and public justification.

In SA, reasonableness received criticism for being too deferential to the scarcity of resources. Griffey points out how reasonableness has been inconsistently employed in different jurisdictions – in the case of the South African Constitutional Court, limitations are due also to the SA constitutional text, which, different from the Covenant, requires only "access to" and not "adequate levels" of economic and social rights.[86] The Court may not have considered fairness in conjunction with two other international norms (progressive realisation and maximum resources). As a result, not enough consideration was given to the practical alternatives that should have been explored in order to fulfill the obligations of the State. The hurdles of adjudication in SA are related to judicial mechanisms entrenched in an administrative law model that could not give reasonableness wide enough scope.[87] Moreover, the views of courts should be distinguished from the prescriptive nature of an HRBA, which is focused on formulating policies and incorporating international standards into practice.

Being an independent legal regime, international law can advance the reasonableness standard in a manner not constrained to the SA jurisprudence, which proved to be incapable of maintaining the criteria it set for itself in

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[84] Ibid, 1, 2

[85] Arosemena (n 77) 105–108.

[86] Griffey (n 81) 314.

[87] Stuart Wilson and Jackie Dugard, 'Constitutional Jurisprudence' in Malcolm Langford and others (eds), *Socio-Economic Rights in South Africa* (Cambridge University Press 2013) 44.

Grootboom.[88] As contended here, reasonableness is the linking element that can offer interpretative support to the obligations (conducts) that are already directly laid down under the Covenant and the Additional Protocol, which could be further interpreted by the CESCR. In this sense, reasonableness is a measure of sufficient effort of progressive realisation and maximum availability of resources as a standard of review recognised in international law.[89]

3 The goal-orient approach to priority-setting using core obligations

Now that I have outlined the implications of the resource generation approach for priority-setting, I will turn to goal-oriented approaches to economic and social rights in priority-setting. I have previously indicated that such a goal-oriented approach should not be supported, especially for lacking legitimacy and conflicting with local fair priority-setting deliberations. I will now explain the concept of core obligations and how they can be used to define a more rigid set of priorities, followed by the reasons for avoiding this interpretation.

Core obligations are held as a set of rights obligations that are reasonably defined by a clear minimum threshold.[90] With this view, beyond this cut-off point in the right to health, the denial of certain healthcare services becomes unjustifiable as a first-order priority.At present, this interpretation remains impractical without a broader consensus over the content of core obligations under international law that would strip from the States the final word on the essential level of healthcare (in their context). As Forman puts it, the absence of a conceptualisation of core obligations precludes the assessment of reasonable steps towards the most pressing health needs for priority-setting or the key issues that should be addressed at the earliest opportunity for the most vulnerable.[91] This section discusses what core obligations could bring to priority-setting if they were better delimited under the right to health and why, given that they are formulated under international soft law, they are not currently a suitable parameter.

Academics are still trying to operationalise core obligations into State practice. A common understanding of the term is that core obligations aim to *"ensure the satisfaction of, at the very least, minimum essential levels of*

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[88] ibid 59.

[89] See e.g. Wilson and Dugard on the reasonableness test in SA: "all it can do is tell us whether the measures actually taken are sufficient", ibid 52.

[90] Arosemena (n 77) 114–117.

[91] Lisa Forman, 'What Future for the Minimum Core? Contextualizing the Implications of South African Socioeconomic Rights Jurisprudence for the International Human Right to Health' in John Harrington and Maria Stuttaford (eds), *Global Health and Human Rights: Legal and Philosophical Perspectives* (Taylor & Francis 2010) 74.

each of the rights are incumbent upon every State party", as per General Comment 3 of the CESCR.[92] This idea, as noted by Tassioulas, creates for human rights claims a benchmark for a minimum floor that is immediately realisable.[93] Another practical result of a core obligation is that it allows drawing attention to and prioritising more persuasive topics in human rights advocacy and practice. As Young notes, the minimum core "trades rights inflation for rights ambition", inasmuch as it reduces the burden of expansive rights interpretation to concentrate efforts and material resources on the most central items to guarantee at least a sufficient realisation for human existence (which, as a downside, may leave other obligations with no timeframes for realisation).[94]

Such status of core obligations is unclear because of the speculative nature of this interpretation. As they are laid down under international law via non-binding instruments, this set of obligations is not well-delineated as a matter of customary law or via interpretation of the Covenant obligations.[95] With little academic consensus on the attributes of core obligations, as well their practical repercussions in resource allocation, the most common instrument that could signal the existence of a minimum right is the CESCR Comments. Among the rights that had their core set out by authoritative interpretation in the General Comments of the CESCR are the right to health, food and education, with such provisions not found in the original treaty.[96]

In the CESCR, health core obligations may not be well enough formulated for specific substantive priorities.[97] As Forman et al note, they are more of a structural set of standards sparing poor countries unreachable aims of substantive realisation of costly health services.[98] That soft and generic approach has been the most recent interpretation derived from General Comment 14, which states obligations that do not in themselves regulate the allocation of resources and establish objective priorities for a specific context:

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[92]CESCR, GC 3 (n 298), para 10.

[93] John Tasioulas, *Minimum Core Obligations: Human Rights in the Here and Now* (World Bank 2017) 4–5. See also: UNGA, "Right of everyone to the enjoyment of the highest attainable standard of physical and mental health" 5 August 2016 (A/71/304) para. 28.

[94] Katharine G Young, 'The Minimum Core of Economic and Social Rights: A Concept in Search of Content' (2008) 33 Yale International Law Journal 64.

[95] Katharine G Young, 'Waiting for Rights: Progressive Realization and Lost Time' in Katharine G Young (ed), *The Future of Economic and Social Rights* (Cambridge University Press 2019) 665–666.

[96] See e.g. CESCR, "General Comment No. 4: The Right to Adequate Housing" 13 December 1991 (E/1992/23) , paras 8-10 and 13; "General Comment No. 12: The Right to Adequate Food (Art. 11 of the Covenant)" 12 May 1999 (E/C.12/1999/5), paras 8, 14 and 17; GC 14 (n 32) paras 43-44; General Comment No. 15: The Right to Water, 20 January 2003 (E/C.12/2002/11), para 37(a)-(i). These instruments are referred in John Tasioulas, 'The Minimum Core of the Human Right to Health' (World Bank 2017) 4 .

[97] Kirsteen Shields, 'The Minimum Core Obligations of Economic, Social and Cultural Rights: The Rights to Health and Education' (World Bank 2017) 23–4.

[98] Forman and others (n 44) 537.

"(a) to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups...
(f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as the right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalised groups"

The right to health has a further complication because its classification creates an intermediate layer of obligations, as per General Comment 14, para 44: the obligations of comparable priority.[99] It could be arguable that after the realisation of core obligations, the next step would be implementing comparable obligations, instead of giving them the same priority.[100] Separating comparable and core obligations, though, is not a straightforward task, given that they are frequently referred to as having equal weight.[101]

Moreover, the classification of the right to health obligations is not an isolated case. Economic and social rights obligations in themselves are already complex to establish, given the limited definition developed in local jurisdictions and the absence of a long-standing jurisprudence of economic and social rights internationally.[102] The concept of core obligations takes this difficulty to a further level, raising questions of what is the minimum necessary in a particular State according to domestic possibilities or as a minimum level that should be regarded as sufficient anywhere in the world.[103] Core obligations can easily be confused with the closely related concept of minimum thresholds, which is a form to operationalise a vital standard of living first proposed by Andreassen

[99] CESCR, GC 14 (n 32) para. 44.

[100] Lisa Forman and others, 'What Do Core Obligations under the Right to Health Bring to Universal Health Coverage?' (2016) 18 Health and Human Rights 23, 28; Tasioulas (n 95) 7.

[101] See e.g. George Jotham Kondowe, 'Implementing Economic and Social Rights in 'Domestic' Jurisdictions: Understanding the Minimum Core Obligations Approach' (2020) 46 Commonwealth Law Bulletin 314, 325; Stephen P Marks, 'Normative Expansion of the Right to Health and the Proliferation of Human Rights' (2016) 49 George Washington International Law Review. 97, 105.

[102] Sepúlveda Carmona (n 45) 7.

[103] Amrei Müller, 'The Minimum Core Approach to the Right to Health Progress and Remaining Challenges' in Sabine Klotz and others (eds), *Healthcare as a Human Rights Issue* (Verlag 2017) 62–63.

et. al in 1985.[104] They both reinforce each other, but it is important to note that they are not always equivalent, as some core obligations are made in the abstract and impose qualitative aspects of the enjoyment of rights (e.g. non-discrimination, participatory process, etc.) that are not a necessary part of a benchmark or a quantitative measurement.[105]

This leads us to a legitimacy problem with core obligations to healthcare, as they can be context-based and not mirror an internationally devised minimum threshold.[106] Core obligations may be an easy achievement for wealthy countries, but for the poorest States, it is more contentious to impose a set of minimum obligations when there is meagre State support, and even more arduous to designate what is the essential level in such a precarious background.[107] For Muller, internationally developed core obligations, "would not cover the vastly different health experiences of individuals around the world, and would thus be ineffective in changing the life to the better of human beings whose individual experiences do not resonate with".[108]

The uncertainty surrounding the development of core obligations at a universal level may hinder their priority-setting application locally. To become functional, a health prioritisation strategy derived from core obligations would necessitate three conditions: a) a list of core objectives must be delineated; b) those objects should be clearly separated from other health claims; and c) the focus of all subsequent actions should be directed towards those core objectives above all else.[109] Arosemena argues that these three elements are difficult to give effect to, because of a lack of boundaries between obligations.[110] It is not immediately obvious how the first obligation can be separated from the others and how to guarantee that all central obligations are realised for the entire population before the remaining issues are realised.

[104] Bård-Anders Andreassen and others, 'Assessing Human Rights Performance in Developing Countries: The Case for a Minimal Threshold Approach to the Economic and Social Rights' (1987) 1997–98 Yearbook of Human Rights in Developing Countries 333.

[105] Kitty Arambulo, *Strengthening the Supervision of the International Covenant on Economic, Social and Cultural Rights: Theoretical and Procedural Aspects* (Intersentia 1999) 141–142.

[106] Katharine G Young, *Constituting Economic and Social Rights* (Oxford University Press 2012) 69–70.

[107] Audrey R Chapman, 'Core Obligations Related to the Right to Health' in Sage Russell and Audrey R Chapman (eds), *Core Obligations: Building a Framework for Economic, Social and Cultural Rights* (Intersentia 2002) 195–196.

[108] Müller (n 105) 75.

[109] Arosemena (n 77) 127–132.

[110] ibid.

These conditions are not fulfilled by core obligations, especially if one relies only on the comments made by the Committee, whose authority to define the precise content of core obligations at a local level may be disputed.[111] The idea of core obligations is not regulated by the Covenant and is simply a separate creation of the Committee with respect to legitimacy and currency in local jurisdictions. Once the Committee commenced operation, it faced the problem of deciding which posture it would take: either by strictly following the text of the Covenant or by helping to clarify the essential aspects of rights, the latter being rebuttable by the States for the Committee's lack of competence.[112] Though the mandate of the Committee is known to have interpretative power and auxiliary supervision of the implementation of the Covenant, such authority does not imply necessarily the creation of new categories of obligations.[113] The Committee has never addressed the issue of its competence to determine core obligations and never tried to respond to criticisms raised by scholars, such as lack of precision and the need for an indication of the rationale for selecting the minimum core of a right. [114]

After surveying the variety of academic arguments for and against core obligations, Forman et al. conclude that the core "requires going considerably beyond the status quo to develop each constituent component of entitlements, content and duties".[115] It can be argued that the core obligations are in fact fundamental for the good implementation of the treaty and, if not recognised, the satisfactory execution of the Covenant's rights would be hindered.[116] Tobin considers, nevertheless, that even if the core is seen as being essential for the realisation of the rights and direct State action, the problem of establishing what are the core obligations still lingers.[117]

To become a rigorous standard, core obligations would need a precise definition to meet the first condition (list of obligations). There is no clear indication of a rationale or special rule of recognition of the core obligations

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[111] On the controversial normative role of the Committee, there is a divide between accepting only "norm-filling" capacity or a true "norm-creating" power. See Mátyás Bódig, 'Soft Law, Doctrinal Development, and the General Comments of the UN Committee on Economic, Social and Cultural Rights' in Stéphanie Lagoutte, Thomas Gammeltoft-Hansen and John Cerone (eds), *Tracing the Roles of Soft Law in Human Rights* (Oxford University Press 2016) 78–80.

[112] Phillip Alston, 'Out of the Abyss: The Challenges Confronting the New U.N. Committee on Economic, Social and Cultural Rights' (1987) 9 Human Rights Quarterly 332, 352–353.

[113] Describing the nature of General Comments can be very nebulous, with their function associated with "guidance", "interpretation" and "understanding" of methods of implementation of rights by the State-Parties. See: Marco Odello and Francesco Seatzu, *The UN Committee on Economic, Social and Cultural Rights: The Law, Process and Practice* (Taylor & Francis 2013) 29.

[114] Bódig (n 113) 77–78.

[115] Forman and others (n 44) 119.

[116] Tobin (n 83) 242–243.

[117] ibid.

already enunciated through General Comments. The Committee has not yet built consensus, though key characteristics have been associated with core obligations (namely, non-derogability, meaning that States are compelled to respect it even when in a state of emergency; minimal level, which points to the lowest level from which all other obligations build; and a sense of urgency, prioritising the core over other needs up to full rights implementation).[118] The formulation of core obligations also depends on how they come into existence (e.g. whether by consensus of States in a common denominator; by interpretation of human principles or values; or through the interpretation of experts in the CESCR). Some scholars expect that the Committee may soon turn to this omission.[119]

Those shortcomings are interwoven with the question of the legitimacy of the Committee in declaring the status and the content of the core concerning national governments. The vagueness over the content of core obligations is long familiar in the context of the reasonableness approach, which has been accused of not fully fleshing out the essential content of which rights should be first satisfied as a matter of urgency.[120] In the South African Constitutional Court, the absence of the clarification of the minimum core has been criticised for not helping the government to make policy choices and plan budgets.[121] This judicial stance has been criticised as a flawed mechanism, failing to ensure immediate relief for those in greater need and to establish precise and coherent scrutiny of grave violations.[122]

There also remain problems with the separation and weight of each core and non-core obligation to create a hierarchy of health prioritisation. A possible interpretation is that progressive realisation prioritises core obligations as being a matter of immediate execution.[123] For instance, the World Bank published a report written by Tasioulas who confidently advances that core obligations are of immediate realisation for all States, independently of the resources available.[124] He notes that justiciability is desirable, in as much as the Committee admits that any right in the Covenant can be brought to court; thus there is no differentiation in terms of obligatory admissibility of such claims. This position concurs with the 1997 Maastricht Guidelines on Violations

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[118] Tasioulas (n 95) 16–20.

[119] Lisa Forman, 'Can Minimum Core Obligations Survive a Reasonableness Standard of Review Under the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights?' (2016) 47 Ottawa Law Review 557, 572.

[120] Marius Pieterse, 'Eating Socioeconomic Rights: The Usefulness of Rights Talk in Alleviating Social Hardship Revisited' (2007) 29 Human Rights Quarterly 796, 810–811.

[121] Sandra Liebenberg, *Socio-Economic Rights: Adjudication under a Transformative Constitution* (Juta and Company Ltd 2010) 142.

[122] Pieterse (n 122) 810–811.

[123] Brems (n 67) 355.

[124] Ibid.

of Economic, Social and Cultural Rights, which proclaim that the core is of immediate effect irrespective of resource insufficiency.[125] However, several scholars have questioned such a posture.[126] For instance, Young objects to the distinction and sequencing of core and other obligations as low or higher priority, similar to the political and economic rights division, claiming that rights should be engaged locally according to the needs of each place.[127]

The tension between a pre-determined core and the local reality grows more complex the further the right-to-health framework is expanded. The following section will analyse this in more detail, considering what can be described as the expansive goal-oriented approach to health priorities and human rights, in the multi-layered domain of GHL.

4. The expansive goal-oriented approach adopting multiple Global Health Law sources

The third approach to prioritisation is formed by GHL and its numerous concurrent sources. Relying on this guidance shares the same shortcomings as the previous goal-oriented model, such as significantly reduced legitimacy compared to local decision-making, but on a larger scale with more contradictory priorities. GHL, as proposed by academics, comprises a blend of traditional hard law and soft law instruments, which collectively form an intended original legal regime aimed at promoting higher standards of public health based on global justice.[128] Among other functions such as disease control and health security, setting global health priorities is one of the purposes of GHL.[129]

In this section, I demonstrate that, although GHL aims to establish priorities and manage resources, its prioritisation is not fundamentally rooted in human rights obligations, potentially leading to incoherence and inconsistencies. There are three primary reasons for this: a) the differing normative status of human rights and GHL instruments, b) the secondary role of human rights in justifying global health instruments, and c) competing priorities between human rights and GHL soft law.

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[125] International Commission of Jurists (ICJ), "*Maastricht Guidelines on Violations of Economic, Social and Cultural Rights"*, 26 January 1997, available at: https://www.refworld.org/docid/48abd5730.html accessed 13 August 2021.

[126] For a review of criticism of the prevalence of core obligations, see :Forman and others (n 44).

[127] Katharine G Young, 'The Immediacy of Economic and Social Rights' (*James g Stewart*, 23 May 2018) <http://jamesgstewart.com/the-immediacy-of-economic-and-social-rights/> accessed 15 June 2020.

[128] This is drawn from Gostin's definition: "the study and practice of international law – both hard law (e.g. treaties that bind states) and soft instruments (e.g. codes of practice negotiated by states) – that shapes norms, processes and institutions to attain the highest attainable standard of physical and mental health for the world's population". Lawrence Gostin, *Global Health Law* (Harvard University Press 2014) 59.

[129] ibid 77.

On the legal status of different sources, GHL, as part of a defended academic interpretation, notably emerged from a law-making process ascribed to the WHO, mostly through soft law, which may be produced independently of HRBA.[130] Soft law instruments come into being as non-binding norms that can be flexibly adopted by states and, in global health governance, have been treated as a flexible means of addressing pressing health issues of international relevance by a more responsive but less formal method. [131] Human rights have gained growing recognition for their relevance to GHL, though the centrality of this connection in global health governance is still controversial.[132] The WHO has been either cautious or inconsistent in taking normative inspiration from human rights frameworks – decision-making at the WHO has been criticised for its utilitarian and economic concerns.[133] There is, of course, a broad range of documents and soft law at the WHO that do refer to the right to health, but that does not automatically mean that the right to health has been taken into account in all international relations or has in practice been used to shape programmes and ground political decisions in all areas, including recommendations on resource allocation.[134]

Hence, GHL instruments may have foundations other than human rights. A case in point are the health policies in the Sustainable Development Goals (SDG), a soft law instrument which may collide with the priority order in the international right to health and possibly local resource allocation decisions.As Tasioulas et. al contend, global health governance need not be solely grounded in human rights and the SDGs have shown that there are

[130] WHO Constitution (1948), Article 21. This article provides the law-making powers of the WHO in the health field related of health threats of international scale of legally binding nature. However, use of this prerogative has been limited. Gian Luca Burci, 'Global Health Law: Present and Future' in Gian Luca Burci and Brigit Toebes (eds), *Research Handbook on Global Health Law* (Edward Elgar Publishing 2018) 492–493.

[131] Those soft law norms are recognised to be passed by intergovernmental organisations: Suerie Moon, 'Global Health Law and Governance: Concepts, Tools, Actors and Power' in Gian Luca Burci and Brigit Toebes (eds), *Research Handbook on Global Health Law* (Edward Elgar Publishing 2018) 34.

[132] For confident views of a vital relationship between human rights and global health governance, see: Lance Gable, 'The Proliferation of Human Rights in Global Health Governance' (2007) 35 The Journal of Law, Medicine & Ethics 534, 13–16. As a counter-point to this suggested interrelation, see Adrien M Viens, 'Interdependence, Human Rights and Global Health Law' (2015) 23 Health Care Analysis 401.

[133] George P Smith, 'Aspirational, Paradoxical, or Oxymoronic?' in Belinda Bennett, Sarah Hawkes and Michael Freeman (eds), *Law and Global Health: Current Legal Issuess* (Oxford University Press 2014) 459–460. Benjamin Mason Meier and Florian Kastler, 'Development of Human Rights through WHO' in Lawrence Gostin and Benjamin Mason Meier (eds), *Human Rights in Global Health*, vol 1 (Oxford University Press 2018) 126; Lawrence O Gostin and others, 'The next WHO Director-General's Highest Priority: A Global Treaty on the Human Right to Health' (2016) 4 The Lancet Global Health e890; BM Meier and W Onzivu, 'The Evolution of Human Rights in World Health Organization Policy and the Future of Human Rights through Global Health Governance' (2014) 128 Public Health 179, 182–84.. For the period of neglect of human rights at the WHO, see: Benjamin Mason Meier, 'Organization, the Evolution of Human Rights, and the Failure to Achieve Health for All' in John Harrington and Maria Stuttaford (eds), *Global Health and Human Rights* (2010) 172–175.

[134] For the history of the right to health and global governance, see: Lawrence Gostin and others, '70 Years of Human Rights in Global Health: Drawing on a Contentious Past to Secure a Hopeful Future' (2018) 392 The Lancet 2731.

aims other than the right to health and principles that foster global health governance. [135]As one of its first architects, Gostin initially drew out the aspirations of GHL around instruments to secure health security and international health threats response, with human rights only exercising a secondary part. His own definition does not conceptualise GHL as explicitly connected to human rights law.[136] Gostin has come to accept the normative importance of the right to health to GHL but noted the imperfect nature of economic and social rights regarding enforceability and ambiguity of content for implementation.[137]

Without integration, some GHL instruments may compete with the set of obligations of the international right to health, since they are not bound by the same priorities. The issue is that if one were to accept GHL soft law, there would be no reason not to accept human rights soft law, such as General Comment 14 (which could arguably be a special kind of source, being the most authoritative form of the right to health interpretation). However, there is no hierarchy in the instruments of global health governance in the form of "human rights soft law" and "health-themed soft law" and no clear direction as to what a consolidated interpretation of the two types of priorities should be (if no rights are referenced), as States could presumably find themselves lost in various, similarly authoritative, recommendations.[138] Human rights obligations, under General Comments 3 and 14, could be interpreted as a strict set of priorities (core obligations), whereas the SDGs have a list of coexisting goals with no hierarchy among them. In contrast to core obligations, target 3 (health) of the SDGs has 17 agreed sub-goals, all with the same weight and not subject to individual opt-out by States.

Additionally, the SDGs and human rights have two different systems of compliance and legal status. The SDGs result from a General Assembly resolution with a different international legal status from treaty-based human rights norms.[139] The High-Level Political Forum is the reporting mechanism for the SDGs voluntarily, which has generated a certain distrust in its efficiency given the lack of rigorous accountability and involvement of

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[135] Tasioulas et. al maintain that the global agenda should go beyond the right to health and uphold also other rights and principles. John Tasioulas and Effy Vayena, 'Getting Human Rights Right in Global Health Policy' (2015) 385 The Lancet e42.

[136] Gostin defines GHL as: "the study and practice of international law— both hard law (e.g., treaties that bind states) and soft instruments (e.g., codes of practice negotiated by states)— those shapes norms, processes, and institutions to attain the highest attainable standard of physical and mental health for the world's population. Normatively, the field seeks innovative ways to mobilize resources, set priorities, coordinate activities, monitor progress, create incentives, and ensure accountability among a proliferation of global health actors". Lawrence O Gostin, *Global Health Law* (Harvard University Press 2014) 59–60.

[137] Lawrence Gostin and Allyn L Taylor, 'Global Health Law: A Definition and Grand Challenges' (2008) 1 Public Health Ethics 53, 59.

[138]For a discussion on the various us possible sources of GHL, see Moon (n 133) 33–36.

[139] UN General Assembly, *Transforming Our World: The 2030 Agenda for Sustainable Development* (UN, 2015).

stakeholders.[140] This contrasts with the concept of accountability within human rights monitoring bodies, which extends beyond mere voluntary reporting and has the authority to declare human rights violations.

Despite these differences, SDGs and the right to health may look superficially similar. For this, it may misleadingly be suggested that achieving one health target on one side will fulfil the right to health obligation on the other. The target of UHC serves as an example. UHC does not entail principles and structural conditions that are expressly described only in the right to health by means of General Comment 14, such as citizen involvement in priority-setting or even the strict observance of a list of services defined as core obligations or obligations of comparable priority. As Puras observes, "not all paths to UHC are consistent with human rights requirements".[141] In this way, SDGs have been accused of being incompatible with human rights for excluding subgroups in those deliberations and in the possibility of achieving UHC by solely extending coverage and not including the most vulnerable or migrants.[142]

Furthermore, other health targets may compete with an equitable realisation of UHC where there are more urgent priorities not explicit within SDGs. For instance, in a country marked by life-expectancy imbalances between rural and urban populations, using more funds to comply with health-related targets without redressing this territorial discrepancy will maintain profound discrimination and inequalities. Adhering to different SDGs targets could probably privilege groups like children, HIV patients or even drivers (e.g. through policies preventing road accidents in SDG 3.6) but will not rigorously promote the full realisation of the right to health with geographical equity. In the end, States need to exercise a level of discretion that only local priority-setting can achieve by using the general principles under economic and social rights.

Within this paper, it would be impossible to determine all instruments that could be used as a source of priority goals. However, it is crucial to note that, similar to core obligations, without explicit criteria across various guidelines and priorities, and lacking the opportunity for decision-making at a local level, states would struggle to follow such guidance in a cohesive manner.

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[140] Format and organizational aspects of the HLPF are set by the following documents: UNGA, "Format and organizational aspects of the high-level political forum on sustainable development (Resolution 67/290) 23 August 2013 (A/RES/67/290), "Follow-up and review of the 2030 Agenda for Sustainable Development at the global level(Resolution 70/299), 18 August 2016 (A/RES/70/299). See also: Åsa Persson, Nina Weitz and Måns Nilsson, 'Follow-up and Review of the Sustainable Development Goals: Alignment vs. Internalization' (2016) 25 Review of European, Comparative & International Environmental Law 59, 61.

[141] Dainius Puras, 'Universal Health Coverage: A Return to Alma-Ata and Ottawa' (2016) 18 Health and Human Rights 7, 8. UNGA, "Right of everyone to the enjoyment of the highest attainable standard of physical and mental health", 5 August 2016 (A/71/304) para. 76.

[142] Chapman, 'Assessing the Universal Health Coverage Target in the Sustainable Development Goals from a Human Rights Perspective' (n 11) 20–22; Claire E Brolan and others, 'The Right to Health of Non-Nationals and Displaced Persons in the Sustainable Development Goals Era: Challenges for Equity in Universal Health Care' (2017) 16 International Journal for Equity in Health 14; Madhulika Sahoo and Jalandhar Pradhan, 'Sustainable Development Goals and Reproductive Healthcare Rights of Internally Displaced Persons in India' (2019) 12 International Journal of Human Rights in Healthcare 38.

Conclusions: Harnessing the international right to health in priority-setting: from a value to standards

The distinguishing feature of economic and social rights principles in international law is neither an orthodox procedural approach to resource allocation nor an inflexible set of priority goals that would override local decision-making. All three alternatives surveyed to interpret the international right to health in priority-setting have weaknesses and benefits. Core obligations are ill-defined but could potentially create a more rigid order between various health provisions. GHL has a great sense of political engagement and international cooperation, but, in its production of new soft law materials that can set different health priorities, it jars with the human rights frameworks and their methods of compliance. The resource generation approach (the very essence of progressive realisation combined with maximum resources) is at least the most coherent prescription, which deserves better attention.

Instead of simply selecting a number of priorities in international law or soft law instruments, this framework is designed to achieve an optimal allocation of resources in priority-setting in different local contexts. An economic and social rights framework can determine whether efforts are being made to address scarcity. It suggests that a lack of resources cannot be used as a blanket justification for all decisions regarding rationing if there are alternative steps that can be taken. States can exert political influence on the causes of scarcity by implementing coordinated policies that mobilise resources and identify priorities altogether. Although still somewhat unclear, the provisions of the ICESCR have more legitimacy than other norms established under soft law (as they do not necessarily contradict local democratic decisions) and could help challenge the belief that scarcity justifies government inaction disguised as priority-setting.

Now, let me discuss the kind of interpretation that can be operationalised into priority-setting in practice. Ffirst, in outlining what can be done with this set of obligations, we have to be clear that even the notion of fair procedures may be knotty and not automatically and unmistakeably adaptable into priority-setting due to numerous difficult questions: for instance, who and how many will make decisions, how appeals are admitted or how to ensure participation.[143] The same problematic implementation goes to reimagining priority-setting as part of economic and social rights resource mobilisation frameworks.

A solid framework for integrating the normative project of economic and social rights into priority-setting is drawn by Charlton et al.[144] They propose a translation process from abstract notions into tangible, pragmatic action through stages, wherein *value*s (“an abstract end that is worth pursuing because it is ‘good’ or ‘right’”)

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[143] On a review of limits to introducing procedural standards, see: Victoria Charlton and Michael J DiStefano, ‘The Ethical Canary: Narrow Reflective Equilibrium as a Source of Moral Justification in Healthcare Priority-Setting’ [2024] Journal of Medical Ethics, 2.

[144] Victoria Charlton and others, ‘We Need to Talk about Values: A Proposed Framework for the Articulation of Normative Reasoning in Health Technology Assessment’ [2023] Health Economics, Policy and Law 1.

trickle down into *principles* (“a general statement that serves as a pledge to act in a certain way”) and *standards* (“practices and codified policies during priority-setting”). If we do acknowledge human rights as central *values* in priority-setting within global health governance, we must adopt State conduct obligations as *principles* (maximum available resources and progressive realisation), alongside local priority-setting standards (access policies embedded into decision-making) that align with the framework established by international law.

In addition, for future research, another layer of complexity, as to resource mobilisation, is to firmly situate where extraterritorial obligations and international solidarity stand within priority-setting given that they do belong to international economic and social rights foundational obligations. Those topics have received great scholarly attention, but still require deeper analysis despite major progress in global health governance to define particular State conducts related to resource mobilisation integrated into priority-setting. A considerable proportion of political economy barriers and market-shaping reforms do not depend solely on local governments, and there is room for international human rights to steer such transformations.[145] A major gap rests on determining the extent to which priority-setting decisions are locally constrained by other States' lack of solidarity or distortions in global health governance and then devising specific and tangible actions.

However, the proposed reading of the right to health involves, at a minimum, integrating priority-setting tools with access policies, rather than treating them as separate issues — for example, by instituting mandatory negotiations, exploring public-private partnerships, or regulating excessive prices. Some necessary measures rely solely on reforms of the often-overlooked legal determinants of scarcity in human rights advocacy, while others necessitate international coordination. As these scarcity conditions may be addressed in many cases, priority-setting can shift towards initially establishing priorities by evaluating their importance and social values and, thereafter, committing to a realisation plan of such elected priorities. This approach aligns more closely with human rights principles, as opposed to prematurely discarding priorities without hesitation when they are deemed unaffordable or less cost-effective. For human rights purposes, these are not justifications as long as the State can fulfil its obligation to establish alternatives to progressively meet those needs or rectify distortions caused by unregulated market forces.

[145] Alicia Ely Yamin, ‘Using Human Rights to Advance Global Health Justice in an Age of Inequality’ (2024) 4 PLOS Global Public Health e0003449.