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LETTER TO THE EDITOR OPEN ACCESS

The Minimum Core Obligations of the Right to Health

Nalakath Arakkal Uvais
Department of Health Research, IQRAA International Hospital and Research Centre, Calicut, Kerala, India

Dear Editor,

The human right to health is a foremost universal moral right possessed by all human beings (1). The origin of the idea of the human right to health can be traced back to the constitution of the World Health Organization (WHO), which defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (2). This well-being conception of health has been endorsed and refined later by many international documents including the Universal Declaration of Human Rights (UDHR) and the International Covenant on Economic, Social, and Cultural Rights (ICESCR)(1). The most prevailing concept in the UN instruments and treaties regarding the human right to health consider health as a 'right of everyone to the enjoyment of the highest attainable standard of physical and mental health (3).

Moreover, social determinants of health have also been added to the concept of the right to health obligations later, making it a more inclusive right. However, such a higher conceptualization of health makes the efforts for respecting, protecting, and fulfilling the obligations under the right to health over-inclusive and poorly differentiated. A pragmatic working plan at the global level to realize the obligations under the right to health may not be feasible and realistic based on the well-being conceptualization of health. There is a need to define the essential aspects of the right to health, which are feasible, acceptable, and affordable, at a global level for the effective implementation and monitoring of obligations under the human right to health. Scholars tried to differentiate between basic health needs from non-basic health needs, to arrive at a working definition guiding the protection of the

Corresponding Author: Nalakath Arakkal Uvais; Department of Health Research, IQRAA International Hospital and Research Centre, Calicut, Kerala, India
E-mail: druvaisna@gmail.com
ORCID: 0000-0003-0961-3025
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human right to health at a global level, that can be enforced by legal means if needed. However, the nature and definition of the core content of a right to health at global remain an issue of enduring controversy. This essay is an attempt to critically examine the issue of defining the minimum obligation of the human right to health.

All the countries across the globe are legally bound to respect, protect, and fulfill the human right to health through international Conventions and treaties (1). However, the over-inclusiveness and poor differentiation of various components of the right to health fail to legally force countries to act proactively to meet the basic health needs of their population. Rather, the concept of progressive realization of the components of the right to health, as defined in Article 2 of ICESCR, allows countries to consider their resource limitations while meeting the obligations under the human right to health (4). In a world of pervasive resource constraints, in the absence of legally enforced duties monitored by institutions, many countries may not be motivated enough to try and meet even the basic health needs of their population. In such a scenario, there is a pragmatic need to identify minimum core obligations arising from a right to health, which need to be immediately complied with by every country, to fulfill the human right to health, at a global level. Thus, the minimum core doctrine (MCD) set a limit to the doctrine of progressive realization and argue for considering a subset of obligations associated with economic, social, and cultural rights as having the following dimensions; immediacy, justiciability, non-derogability, and having a special value, that demand for immediate coordinated action across various stakeholders with international organizations (4). Defining such minimum obligations can foster coordinated universal actions of resource mobilization to fulfill the basic health needs of communities belonging to poor countries. Under MCD approach, a minimum threshold could help to measure the status of a right to health at the global level. Each stakeholder can be made accountable regarding their obligations towards achieving this minimum core obligation. Moreover, legal experts can define legal obligations arising out of minimum core obligations clearly so that individuals can protect their health rights better and can make stakeholders in the health sector accountable for violating minimum core obligations.

Despite having a consensus regarding the relevance of MCD in the realization of the human right to health at the global level, most of the documents dealing with the right to health fail to define minimum core obligations with clarity. Many a time, the documents speak about inclusive rights to health, by including rights belonging to other rights, making minimum obligations very broad, poorly defined at the practical and legal level. The controversy between the UN experts in human rights, Professor John Ruggie and Professor Paul Hunt, regarding the minimum obligations of pharmaceutical industries in realizing the right to health, highlights the same issue of lack of clarity regarding minimum core obligations even at the highest level. According to Ruggie, pharmaceutical corporations merely have the responsibility to respect the obligations under the right to health (5). However, Hunt argued for higher responsibilities for corporates, similar to the state's responsibilities (5). Moreover, such a confused understanding of MCD may not offer a principled and coherent rationale for its implementation, especially in the contexts

of resource-poor countries where the right to health must be operationalized, and burden poor countries with financially unrealistic obligations (4). Similar confusion regarding the determinacy and the feasibility of the content of minimum core obligations can also be seen in various regional and state laws. E.g.; In a case regarding the obligations of the state in providing costly medicines for treating a rare and chronic disease, the Indian supreme court ruled that the right to essential medicines is a non-derogable minimum obligation under the right to health and the government should fulfill it even though the treatment is expensive and recurring (4). In a developing country like India, such a conceptualization of MCD might lead to financially unrealistic obligations on the state, and there would be no money left for anything else. The conceptualization of basic health needs under MCD should also be guided by feasibility as well as affordability of the health needs, especially in a resource-poor setting. Moreover, contextual factors also need to be taken into consideration while drafting activities to implement minimum core obligations. Hence, there is a need to find a common ground regarding minimum core rights as well as duties with regards to the right to health. However, there is a broad consensus regarding the corresponding minimum duty across institutions. Most of the scholars and institutions agree that the minimum duty corresponding to human rights to health can be a negative responsibility to respect the right to health, by avoiding activities that violate others' rights to health.

In conclusion, the idea of minimum core obligations to the human rights to health is still evolving. A close reading of the international documents discussing MCD, especially WHO and UN documents, and the works of human rights scholars, provides insights into the controversial nature of this concept at the global level. However, a workable definition of MCD will be greatly helpful in prioritizing major goals, that are non-derogable and demands immediate action from every stakeholder, in realizing the obligations under the human rights to health, from an ever-increasing diverse range of goals envisaged by the well-being conception of health. Under the framework of MCD, the basic health needs can be effectively implemented and monitored, and workable institutions can be made to realize the minimum obligations under the human right to health, at a global level.

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Contact Details

Nalakath Arakkal Uvais
Department of Health Research,
IQRAA International Hospital and Research Centre, Calicut, Kerala, India
E-mail: druvaisna@gmail.com
ORCID: 0000-0003-0961-3025

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