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THE RIGHT TO HEALTH IN INTERNATIONAL LAW: CONTESTATIONS OF ITS COHERENCE AND THE ARGUMENT OF NON-JUSTICIABILITY IN NIGERIA

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Abstract

The right to health in international law has been characterised by the extremes of great enthusiasm and optimism by proponents and deep indifference and pessimism by opponents who doubt that the concept is coherent, definable, politically viable, economically sustainable or justiciable. As such, the discourse occupies a highly contested space in international human rights law and its implementation is a matter of much disagreement for advocates and opponents at the international and domestic level. In view of this situation, this paper aims to achieve three main objectives: first, to identify and present in a coherent manner the key questions/issues that have defined the character and content of the body of work on the right to health in international law; second, to clarify the contentious issues in theory and praxis that have more or less informed (and continue to do so) the trajectory in which the right to health currently travels; and third, to identify how the claim of indeterminacy in the international framework on the right to health has provided an opportunity for countries like Nigeria to refrain from engaging with that right in their domestic system. The overarching argument here is that as a result of the contestations that have characterised the right to health discipline in the international system, successive administrations in Nigeria have wittingly or unwittingly been armed with (more or less) powerful arguments which have been used to deprive Nigerian citizens of the benefits of the right to health in the domestic system of Nigeria.

Keywords: Right to health, international law, justiciability, Nigeria, theory, praxis.

INTRODUCTION

This paper makes the claim that successive administrations in Nigeria have not had compelling reasons to implement the right to health in the country's health system because of controversies which characterise claims about the right to health in international law. In support of this hypothesis, four key arguments are advanced: firstly, that the formulation of the right to health in international law is without a consistent account of its meaning and content; secondly that this has made claims about the right to health controversial and difficult to substantiate; thirdly, this has further led to a weak monitoring regime in the international system; and finally, this failure to resolve the debate about the meaning and content of the right to health has resulted in far more deleterious consequences for domestic systems such as Nigeria.

The paper is structured into five parts, excluding this introductory section. Part two examines the argument that the formulation of the right to health in international law is without a consistent account of its meaning and content. Part three addresses the claim that the controversy about the meaning and content of the right to health has made it a difficult right to substantiate. Part four considers how this development has resulted in a weak monitoring regime in the international system. Part five examines how the failure to resolve the debate about the meaning and content of the right to health has resulted in far more grave consequences for the domestic system of Nigeria. Part six concludes the paper argument that the reason why the claim of a non-justiciable right to health continues to gain traction in Nigeria is because of the unresolved situation of that right in international law.

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The Right to Health lacks a Consistent Meaning in International Law

The right to health does not have a consistent meaning in international law. This is because all the international instruments which define the right couch it in different ways, investing on it different meanings and consequences. To illustrate this point, table 1 below presents a summary of the definitions of the right to health offered by the Constitution of the World Health Organization (WHO); Art 25 of the Universal Declaration of Human Rights (UDHR); Art 12 of the International Covenant on Economic Social and Cultural Rights (ICESCR); Art 12 of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and Art 24 of the Convention on the Rights of the Child (CRC).

Table 1: Summary of the Definition of the Right to in International Instruments

Preamble to the WHO Constitution	…state of complete physical, mental and social well-being and not merely the absence of disease or infirmity… (WHO, 1946).
Art 25 UDHR	…right to a standard of living adequate for health and well-being of a person and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control (Universal Declaration of Human Rights, 1948).
Art 12 ICESCR	…the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (International Covenant on Economic, Social and Cultural Rights, 1966).
Art 12 CEDAW	…appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on the basis of equality of men and women, access to health care services, including those related to family planning (Convention on the Elimination of All Forms of Discrimination Against Women, 1981).
Art 24 CRC	…the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. State Parties shall strive to ensure that no child is deprived of his or her right of access to such health services (Convention on the Rights of the Child, 1989).

Claims about the Right to Health are Difficult to substantiate

Claims about the right to health are difficult to substantiate as a result of the inconsistency of its meaning in international law. A multitude of interpretative dilemmas have arisen from the formulation of health, and the right to health, respectively, in international law. For instance, the formulation of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" and "the enjoyment of the highest attainable standard of health" as a fundamental right of every human being (WHO, 1946) has given rise to questions such as: What is the meaning of the highest attainable standard of health? What is the meaning of health? Does it extend to the social determinants of health? What obligations flow from the requirement that states recognise the right to health? Are the measures required to fulfil these obligations universal or do they differ between states? What is the minimum core of the right to health? To what extent should states be responsible for ensuring the health of an individual in the home, workplace, and general community? To what extent must states prevent threats to an individual's health from non-state actors? Is privatization of health care services compatible with the right to health? Is the right to health justiciable? To what extent must intellectual property rules be designed to maximise access to medicine and medical services? (Tobin, 2012)

Two distinct approaches to these interpretative dilemmas are evident in the literature. The first responds to questions on the meaning and content of the right to health by focusing on its praxis. Scholars like (Daniels, 1985), (Kass, 1981) and others who favour this approach tend to substitute WHO's definition of health with one which they feel is more in accord with "medical research, education, knowledge and practice." (Tobin, 2012) The second approach (which is only beginning to take hold) focus attention on the theoretical basis of the right to health. Scholars like (Ruger, 2006) and others who favour this approach have done considerable work in formulating a theory of the right to health.

A Weak Monitoring Regime in International Law

A number of mechanisms have been developed in international law to monitor the implementation of the right to health. However, these mechanisms have not been as effective as they ought to be in making states implement that right in their domestic system because of the disagreements which continue to characterise claims about the right to health. These mechanisms include the Universal Periodic Review (UPR) of the Human Rights Council, Treaty-based bodies responsible for each of the treaties on the right to health (see Table 1 above), and regional human rights bodies responsible for implementation of regional treaties on the right to health (see Figure 1 below).

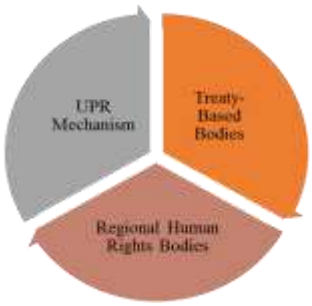

Figure 1: International Mechanisms for Monitoring the Implementation of the Right to Health

A manifestation of this problem is seen in the way these mechanisms are very slow to bring about any changes to domestic policy on the right to health. When states are subjected to the scrutiny of these mechanisms and recommendations are proffered which require states to give meaning to the right to health in their domestic systems, many states (Nigeria inclusive) simply ignore these recommendations and no changes are effected.

The Consequences of the Controversy on the Right to Health in Nigeria

The failure to resolve the debate about the meaning and content of the right to health has not benefited domestic systems like Nigeria where health outcomes are very poor. Whereas the health system of Nigeria would have greatly benefited from the prioritisation of health in government policy and action, lack of engagement with the right to health, which would have provided the basis for such prioritisation, has resulted in a highly dysfunctional health system with consistently poor health outcomes. The evidential basis for the above claim is provided by several indicators, three of which are examined here, namely: the maternal mortality rate; health financing by government; and out-of-pocket health expenditure by households.

With respect to the maternal mortality rate, a cross-country comparison has been made in this paper of Brazil, India, South Africa, Sri Lanka and Nigeria for the period 1995 to 2008. The trend indicates that within this period, Nigeria has had a significantly higher rate of maternal mortality than all the other countries mentioned. Although a steady decline in the maternal mortality rate of Nigeria is noticed, it is still significantly higher than the situation in the other countries. See the Chart in Figure 2 below which provides illustration of this phenomenon.

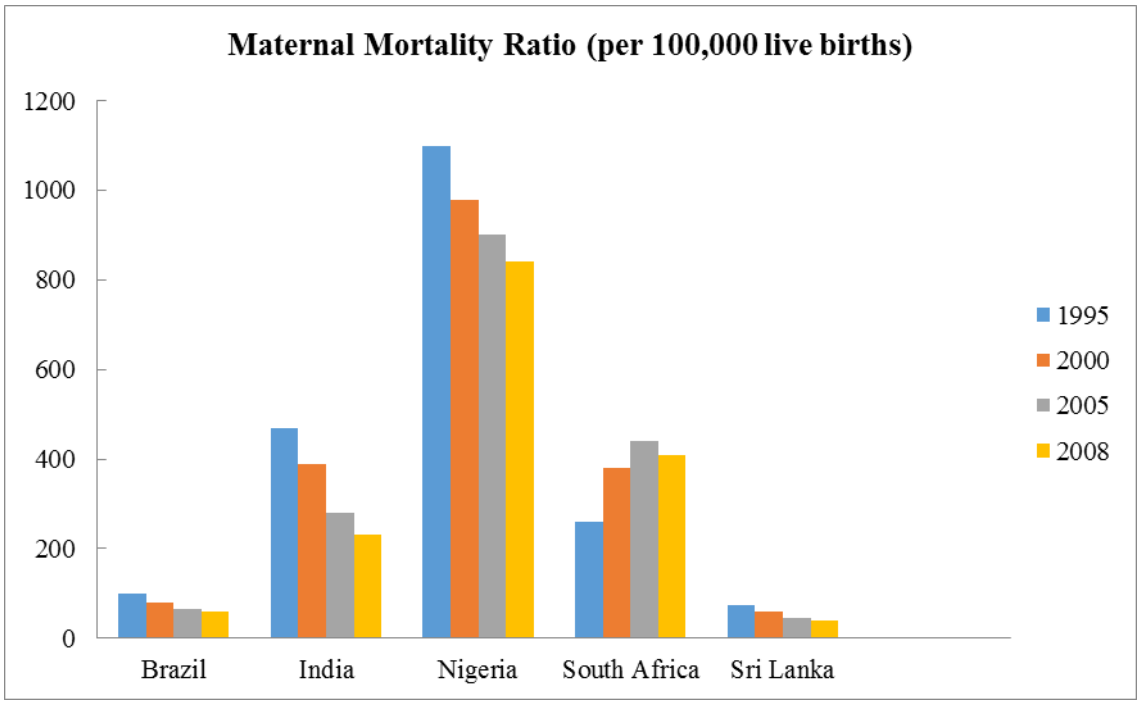

Figure 2 (Source: WHO Global Health Expenditure Database)

With regards to health financing by government, which measures the general government expenditure on health, this indicator shows how much, per capita, is being committed to health care (WHO, 2011). It is an important measure of the priority government gives to health in any domestic system. A cross country comparison was carried out of Brazil, India, South Africa, Sri Lanka and Nigeria on this indicator. The comparison covers the period 2009 to 2013. The result shows that within this period, Nigeria has consistently maintained the lowest general government expenditure per capita. Only India comes close to achieving this poor record. See Figure 3 below for further illustration.

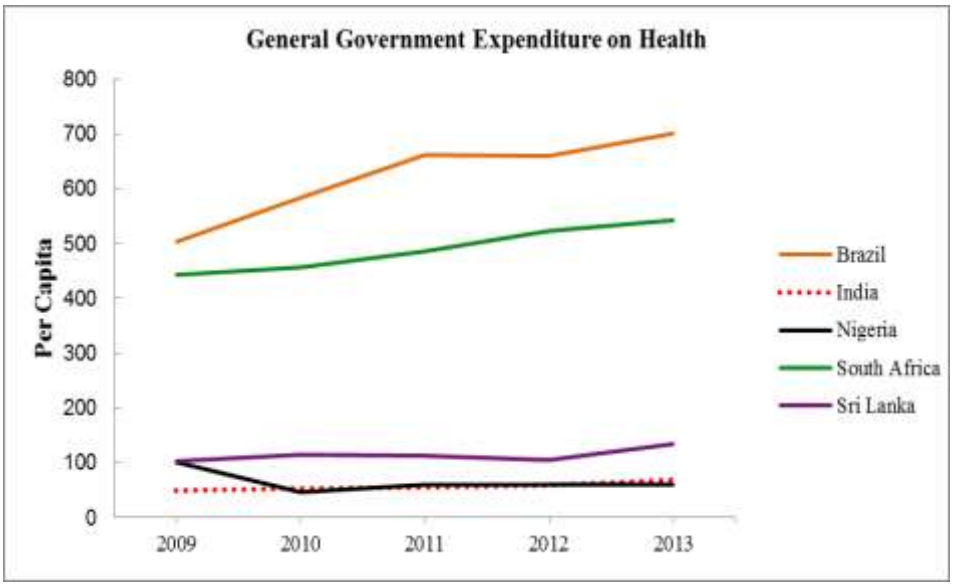

Figure 3(Source: WHO Global Health Expenditure Database)

Finally, out-of-pocket expenditure by households is a core indicator of health financing systems which contribute to understanding the relative weight of direct payments by households in total health expenditures. High out-of-pocket payments for health are strongly associated with catastrophic and impoverishing spending. As such it is a key support for equity and planning processes (WHO, 2011).

An analysis of the situation of out-of-pocket expenditure in Brazil, India, South Africa, Sri Lanka and Nigeria has been undertaken in this paper. The period covered by the analysis is 2009 to 2013. The findings indicate that Nigeria has the highest percentage of out-of-pocket expenditure as a percentage of total health expenditure (WHO, 2011). Further illustration is provided by figure 4 below.

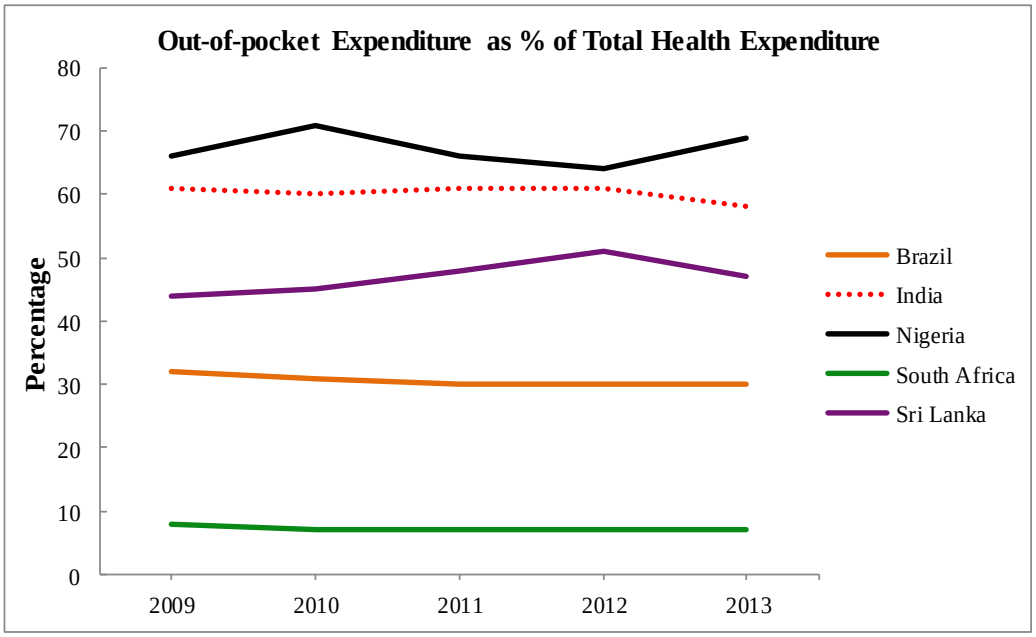

Figure 4 (Source: WHO Global Health Expenditure Database)

CONCLUSION

In concluding this paper, the question is posed: What are claims about the right to health really all about? It is argued that this is the question which ought to be addressed in arriving at a meaning of the right to health. This will serve as a precursor to the specification of its content. For this to happen, a theory of the right to health is needed. Those who dismiss the right to health sometimes refer to the absence of a theory as a basis for doing so (Hunt, 2007). It is for this reason that the contribution of the likes of (Ruger, 2006) is very important. As she offers, as "the beginnings of a theory of the right to health" the formulation that the right to health is a "…demand for equity in health and the need for the internalisation of public moral norms to progressively realise this right" (Ruger, 2006).

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